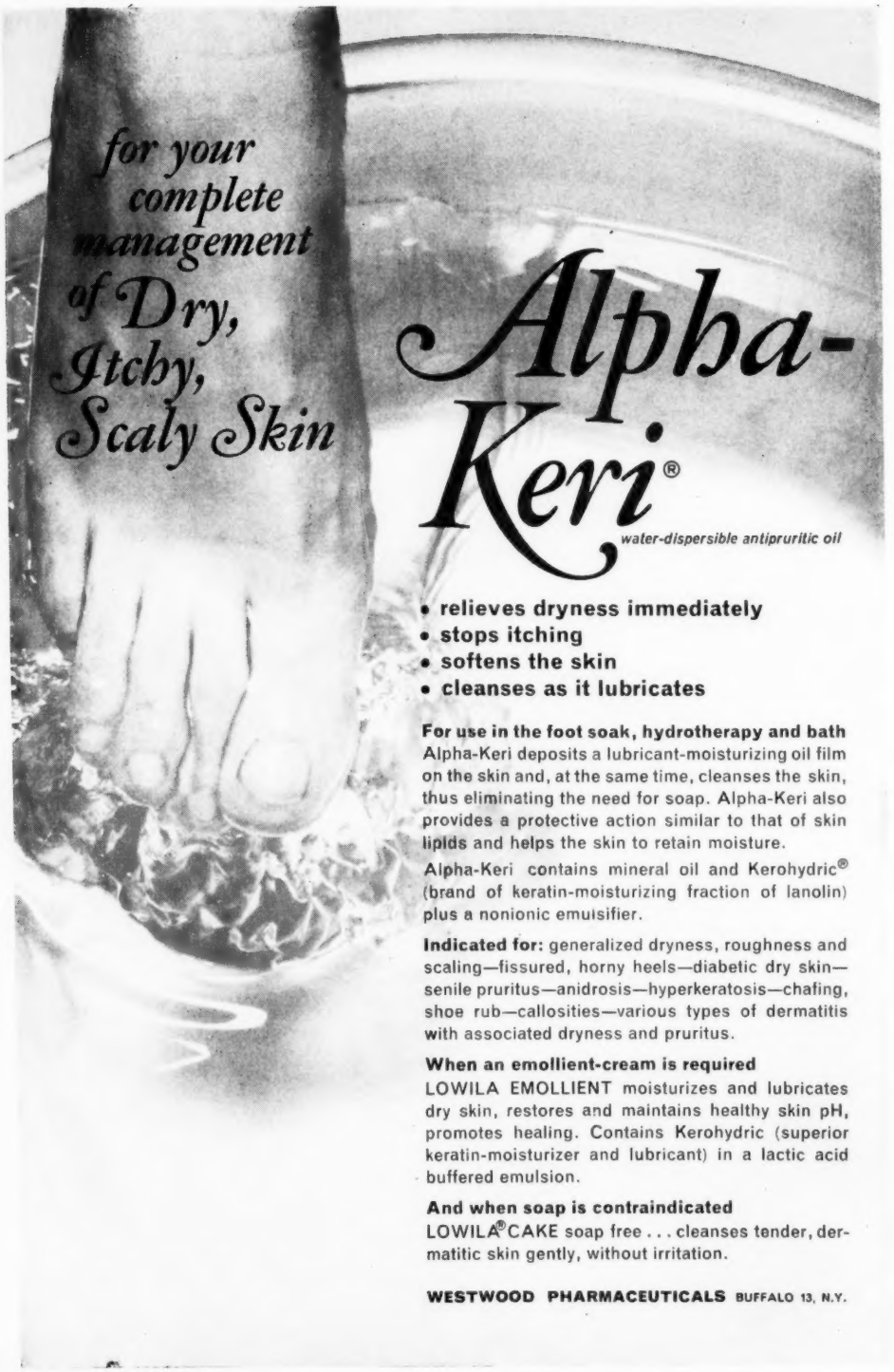
MARCH 1961
Volume 51, Number 3

JOURNAL OF THE AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

TABLE OF CONTENTS—162


for your complete management of Dry, Itchy, Scaly Skin
Alpha-Keri®
water-dispersible antipruritic oil
• relieves dryness immediately
• stops itching
• softens the skin
• cleanses as it lubricates
For use in the foot soak, hydrotherapy and bath
Alpha-Keri deposits a lubricant-moisturizing oil film on the skin and, at the same time, cleanses the skin, thus eliminating the need for soap. Alpha-Keri also provides a protective action similar to that of skin lipids and helps the skin to retain moisture.
Alpha-Keri contains mineral oil and Kerohydric® (brand of keratin-moisturizing fraction of lanolin) plus a nonionic emulsifier.
Indicated for: generalized dryness, roughness and scaling—fissured, horny heels—diabetic dry skin—senile pruritus—anidrosis—hyperkeratosis—chafing, shoe rub—callosities—various types of dermatitis with associated dryness and pruritus.
When an emollient-cream is required
LOWILA EMOLLIENT moisturizes and lubricates dry skin, restores and maintains healthy skin pH, promotes healing. Contains Kerohydric (superior keratin-moisturizer and lubricant) in a lactic acid buffered emulsion.
And when soap is contraindicated
LOWILA® CAKE soap free . . . cleanses tender, dermatitic skin gently, without irritation.
WESTWOOD PHARMACEUTICALS BUFFALO 13, N.Y.

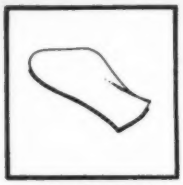
Journal of the American Podiatry Association. Published monthly at Boston, Mass. Second Class Postage Paid in Boston, Mass.

Musebeck KUSH-N-ARCH® casuals

DEEP DOWN BASIC COMFORT COMBINED WITH SMART STYLING

CUSHION HEEL SUPPORT

Glove-soft, lightweight uppers patterned for comfort fitting. Cushioned support from heel to toe.



CUSHION ARCH SUPPORT

WEDGE SUPPORT

Cork platform ⅛" thick cushions and supports. Wedge insole for inner longitudinal support. Outsole ¼" cushion crepe. Will accept accommodations.

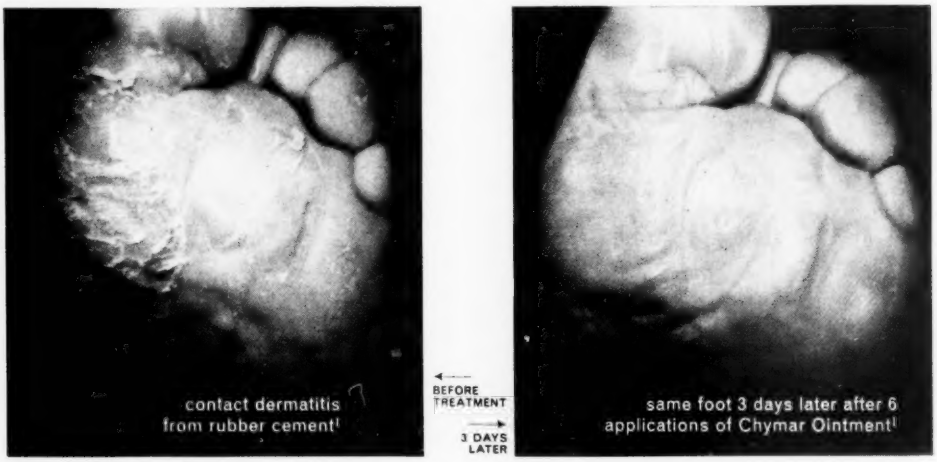
CUSHIONED OUTSOLE

Your patient will be delighted when you prescribe these new unique "Kush-n-arch" casuals. Musebeck has put all the basic comfort features into this foot supporting shoe without sacrificing smart style. The doctor gets what he wants—the patient likes what she wears.

COLORS: white, black, red, smoked elk.
Widths 4A, 2A, B and D available in sizes 4½ to 11; (Moderately Priced).

MUSEBECK SHOE COMPANY — Forest and Westover — Oconomowoc, Wisconsin

To see is to believe the advantages of . . .



Chymar® Ointment

in common foot lesions

"Chymar Ointment contains ingredients that are specific and at the same time collective in their effect. It works against many skin conditions to control inflammation, to eliminate and prevent infection, and to clean wounds." [1]

For example, in 380 patients with dermatologic foot problems* Chymar Ointment was 97.5% effective. Prompt relief of acute pain was achieved in most cases within 72 hours and pruritus was controlled even faster. Inflammation was reduced within 2 days . . . tenderness owing to edema in even less time.[1] A second report[2] concludes "that podiatric lesions treated with chymotrypsin ointment (Chymar Ointment) respond rapidly without noticeable side effects" and the ointment can "eliminate the necessity of adhering to routines that are either inadequate or perhaps too slow to make treatment worthwhile." And finally, Streiker has used Chymar Ointment successfully in the management of diabetic, varicose and traumatic foot and leg ulcers, burns, a number of dermatoses including fungus infections and infected helomata.[3]

Each gram contains: hydrocortamate HCl, 1.25 mg.; neomycin palmitate (as base) 3.5 mg.; proteolytic activity (provided by a concentrate of proteolytic enzymes from pancreas, e.g. chymotrypsin and trypsin) 10,000 Armour Units; in a water-miscible ointment base. Available in 1/6 oz. and ½ oz. tubes.

*Tylomata, Helomata, Local Abscesses, Allergic Dermatitis, Inflamed Nail Grooves, Nail Removal, Heel Fissures, Ulcers, etc.

1. Walker, M. H.: The Therapeutic Use of a Corticosteroid-Antibiotic-Enzyme Ointment in Common Foot Lesions, to be published. 2. Lucas, R. D.: Current Podiatry (March) 1960. 3. Streiker, F. B.: The Use of Chymotrypsin in Foot Orthopedics. Paper Presented at the Annual Meeting, American Podiatry Association, Chicago, Illinois, August, 1960.

ARMOUR PHARMACEUTICAL COMPANY KANKAKEE, ILLINOIS
Armour Means Protection

© 1960, A. P. Co.

New—for treatment of tinea pedis . . .

Tinea trichophytosis of long duration—before treatment.

Marked clearing of lesions and infection after treatment with CUPERTIN cream.
(photos courtesy of Dr. N. Lambert, Nutley, N.J.)

Topical **CUPERTIN**™ cream
(diphenylpyraline hydrochloride, 2%)

directly fights infection

dramatically stops itch

CUPERTIN cream is a unique, new *single* chemical with two distinct pharmacologic actions:

1) antifungal—highly effective against many fungi

2) antipruritic—for immediate relief of itching

. . . and CUPERTIN cream is virtually non-sensitizing.

In controlled studies[1-3] of treatment of fungal infections, particularly tinea pedis, diphenylpyraline hydrochloride, 2%, proved to be a highly satisfactory agent in clearing the underlying fungus infection. The marked antipruritic property of the drug promoted prompt healing of lesions, reducing the urge to scratch and the danger of secondary infection.[1-4]

Non-sensitizing CUPERTIN is available on your prescription in 15-Gm. (½-oz.) tubes of diphenylpyraline hydrochloride, 2%, in a stainless, hydrophilic cream base.

1. Sokoloff, O.: A.M.A. Arch. Dermat. and Syph. *64*:754, 1951. 2. Van De Erve, J.: A.M.A. Arch. Dermat. and Syph. *68*:572, 1953. 3. Bleiberg, J.: personal communication. 4. Tobey, J.: personal communication.

Samples on request

COOPER, TINSLEY Laboratories / Harrison, N.J.

THE AMERICAN PODIATRY ASSOCIATION

BOARD OF TRUSTEES

Marvin D. Marr, *President*
305-307 S.G.A. Building, Cedar Rapids, Iowa

Robert Shor, *President Elect*
4480 Crenshaw Boulevard, Los Angeles, California

Benjamin C. Mullens, *Vice President*
Security Mutual Bldg., Binghamton, New York

Joy E. Adams, *Vice President*
Florida National Bank Bldg., St. Petersburg, Fla.

Marvin W. Shapiro, *Retiring President*
1059 Spitzer Building, Toledo, Ohio

Ralph E. Owens
1700 Exchange Blvd., Oklahoma City, Okla

Earl G. Kaplan
14608 Gratiot Ave., Detroit, Michigan

James A. Conforti,
767 Broadway, Bedford, Ohio

Harry I. Horowitz
30-96 Steinway St., Astoria, L. I., New York

L. B. Thompson
5613-7th Ave., Kenosha, Wisc.

William A. Edwards
150 No. Arlington Ave., Reno, Nev.

HOUSE OF DELEGATES

Speaker, Leo N. Liss, 209 Post Street, San Francisco, California
Vice-Speaker, Jonas C. Morris, 108 West Merchant Street, Audubon, New Jersey

HEADQUARTERS STAFF

A. Rubin, *Secretary*
Seward P. Nyman, *Assistant Secretary*
Francis A. Kalbacher, B.S., M.A., *Assistant Director*

Assistant to the Secretary
Angeline R. Jackerson

Assistant to the Treasurer
Mary H. Blair

Assistant to the Editor
Lottie S. MacConnell

Secretary
Marcia I. Fischer

Clerks
Patricia A. Farmer
Inés M. Dediot

Administrative Assistant
George A. Dame

Membership Records
Catherine M. Vogel

JOURNAL OF THE AMERICAN PODIATRY ASSOCIATION

All expressions of opinion and all other statements are published on the authority of the writer over whose signature they appear, and are not to be regarded as expressing the views of the American Podiatry Association, unless such statements or opinions have been adopted by the Association.

Deadline for **Journal** copy is the 10th of the month preceding the month of publication. (Example: copy for June issue should be in the editorial offices by May 10th.) The **Journal** is usually mailed between the 10th and 15th of the month of issue (the June issue is mailed between the 10th and 15th of June).

Manuscripts must be typewritten, double spaced, and an original and one carbon copy must be submitted. References should give name and initials of author, volume, page, month and year of publication in the case of periodicals, and publisher and place and year of publication in the case of books. Illustrations must be clear photographs. Glossy prints are preferred. Drawings must be made in black ink on heavy paper or cardboard. Any illustrations should bear the author's name and be numbered in the order in which reference is made in the text. Illustrations and tables must be mounted separately and not in the manuscript. Legends should be placed on a separate sheet. Tables are not illustrations and should be numbered separately. Articles are accepted with the understanding that they have not been published previously and that they are submitted solely to the **Journal**.

Orders for reprints must be placed at the time the author is notified of publication date.

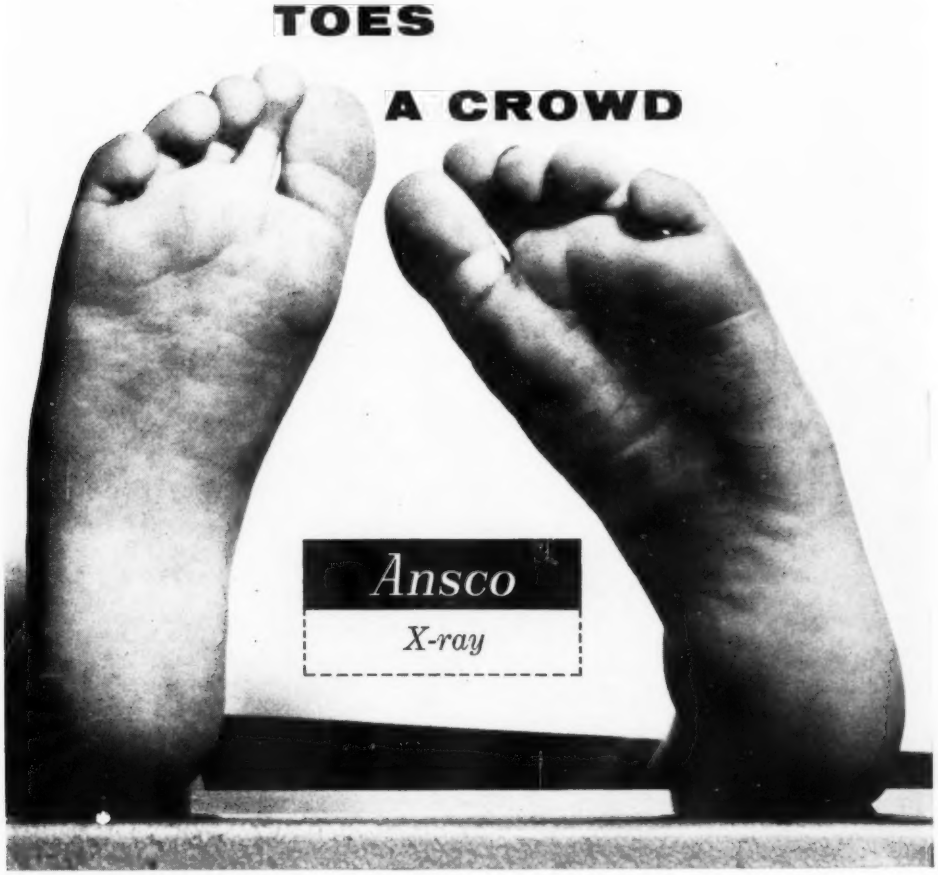
Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor; those regarding advertising to the National Advertising Representative. Advertising and editorial copy must conform to the official standards established by the Association.

Subscription is included in the annual membership dues of the American Podiatry Association. The subscription rate for non-members is $10.00 a year in advance ($1.50 additional for foreign postage, exclusive of Canada, Cuba, Mexico). Single copies $1.00 each. Remittance should be made payable to the American Podiatry Association, 3301 Sixteenth St., N.W., Wash. 10, D. C.

When you're jammed for time and diagnosis must be quick and sure, Ansco X-ray films provide the clean, certain readability so necessary to critical evaluations.

If you would like a side-by-side comparison between the film you are now using and Ansco Non-Screen Monopak®, write Ansco, X-ray Sales Dept., Binghamton, N. Y.

This will be the quickest way toward turning the "pressure off," radiographically speaking of course. Ansco, Binghamton, N. Y., A Division of General Aniline & Film Corporation.



JOURNAL
OF THE
AMERICAN PODIATRY
ASSOCIATION

The Official Publication
of the
Podiatry-Chiropody Profession

3301 16th Street, N. W.
Washington 10, D. C.
NOrth 7-4587

Editor
A. Rubin

Assistant to the Editor
Lottie S. MacConnell

Abstract Editor
Florence A. Cooksley, A.B., M.A.

National Advertising Representative
The Gordon M. Marshall Company
30 West Washington Street
Chicago 2, Illinois
15 West 44th Street
New York, N. Y.

EDITORIAL ADVISORY BOARD

Samuel Brezak, New York; Conrad Dahl, Illinois; Lawrence Frost, Michigan; Felton O. Gamble, Arizona; Milton Henenfeld, New York; Harry Hoffman, Dist. of Columbia; Charles E. Krausz, Pennsylvania; Raymond K. Locke, New Jersey; Lyle R. McCain, Illinois; Jonas C. Morris, New Jersey; Pierce B. Nelson, California; Ralph E. Owens, Oklahoma; John T. Sharp, Pennsylvania; Robert Shor, California; Marvin D. Steinberg, New York; Harold Wheeler, Illinois; Irving Yale, Connecticut; Louis P. Zulli, Pennsylvania.

Indexed in Index Medicus, formerly Current List of Medical Literature, National Library of Medicine.

Notice of change of address should be received six weeks before the change is to become effective. Old and new address must be given.

The Journal of the American Podiatry Association is published monthly and copyrighted in 1961 by the American Podiatry Association.

Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879, re-entered March 3, 1958. Publication office, 375 Broadway, Boston, and Editorial Executive offices, 3301 16th St., N.W., Washington 10, D. C.

TABLE OF CONTENTS

Retarded Osseous Development as A Primary Factor in Weakfoot 183
Joseph R. Cinzio, D.S.C., F.A.C.F.O.

The Fabrication of Contact Appliances For Use in Conventional Footwear 189
Samuel Rosoff, Pod.D.

The Need for Specialized Shoe Lasts to Accommodate The Commonly Occurring Foot Pathologies and Gross Structural Deviations 195
D. D. Ressler, D.S.C.

A Device for Measuring Foot Deviations 203
H. H. DiPiero, D.S.C.

A "Barefoot" Plantar Appliance 206
Morton H. Walker, D.S.C.

President's Message: Yes, We Do Have a Personal Responsibility 208

Council on Education, Forty-first Annual Report 209

Career Guidance Information Furnished 214

Insurance Needs of the Professional Man 216

Organization News 219

Women's Auxiliary Message 223

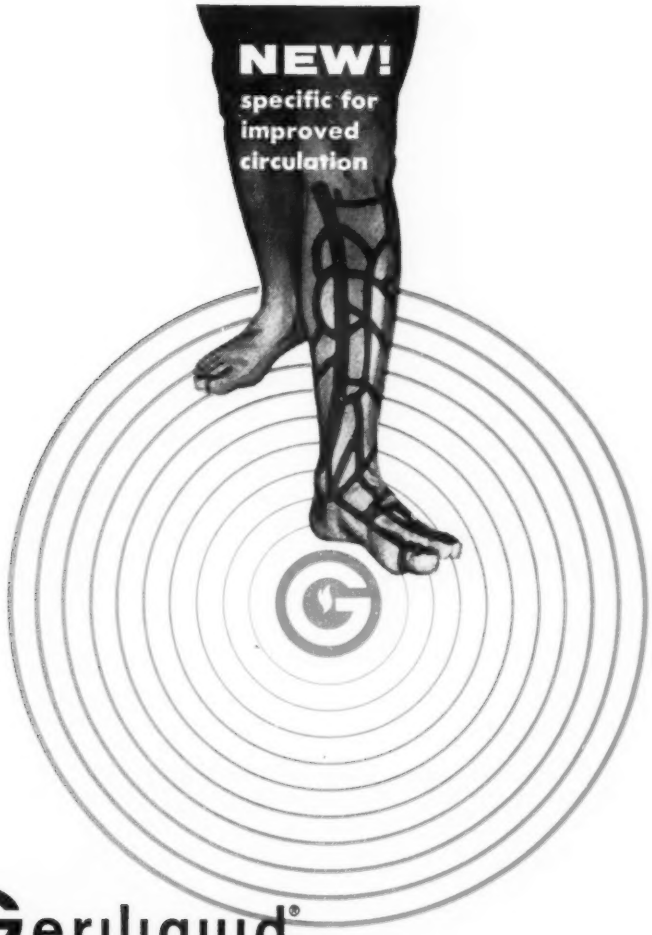
Deaths Reported 224

Dates to Remember 225

Mood Elevators 226

Advertisers Index 227

Classified Ads 228



Geriliquid®

NIACIN AND GLYCINE

PROVIDES SUSTAINED WARMTH OF EXTREMITIES

In patients with impaired peripheral circulation, Geriliquid warms cold hands and feet through rapid, safe vasodilation by niacin, and provides continuing sustained vasodilation and heat radiation by the thermogenic action of glycine.

Other Benefits:

- **Increases ability to walk farther with less pain**
- **Relieves pain, dizziness and faintness**
- **Improves appetite and brightens the mood**

Composition: Each 5 ml. contains: Niacin 75 mg., Glycine 750 mg. in a sherry wine base. Contains Alcohol 5%.

Dosage: One or two teaspoons three times daily before meals.

Supplied: 8 oz. bottles. 72250

LAKESIDE LABORATORIES, INC.
Milwaukee 1, Wisconsin

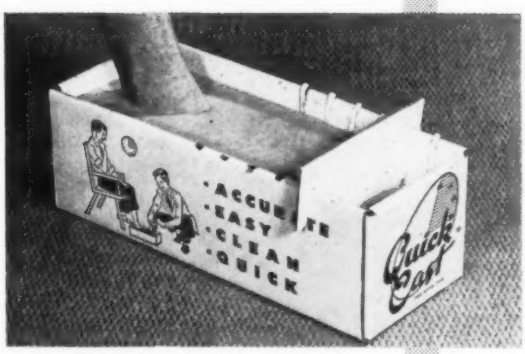
COMPONENT STATE SOCIETIES

Showing Society, President and Secretary

Alabama Association of Chiropodists	John G. Veres, Jr., 215 Bartlett Bldg., Montgomery, Ala. Edward E. Sealy, 39 S. Perry St., Montgomery, Ala.
Arizona Podiatry Association	Daniel R. Nenad, 205 E. Camelback Rd., Phoenix, Ariz. Irwin D. Shapiro, 40 E. Thomas, Phoenix, Ariz.
Arkansas Podiatry Association	George F. Heroman, Jr., 808 Popular St., Pine Bluff, Ark. Walter C. Gigerich, Arkansas Nat'l Bank Bldg., Hot Springs, Ark.
California Podiatry Association	William F. Eads, 1651 Garnet St., San Diego, Calif. Robert O. Johns, 209 Post St., #809, San Francisco, Calif.
Colorado Podiatry Association	J. M. Metz, 317 Empire Bldg., Denver, Colo. Edward E. Pellegrini (Ex. Sec.), 2731 S. Colorado, Denver, Colo.
Connecticut Podiatry Association	Seymour Jacobson, 254 College St., New Haven, Conn. Margaret L. Halloran, 75 Pratt St., Hartford, Conn.
Delaware, Chiropody Society of	Harold Friedman, 2000 Baynard Blvd., Wilmington, Del. James C. White, 119 Federal St., Milton, Del.
District of Columbia Podiatry Society	Edward Ganny, 1907 Eye St., N.W., Washington 6, D. C. Alvin J. Sollod, 2033 Rhode Island Ave., N.E., Washington 18, D. C.
Florida, Podiatry Association of	John J. McCaffrey, 303 Blount Bldg., Fort Lauderdale, Fla. Joy E. Adams, 401 Fla. Natl. Bank Bldg., St. Petersburg, Fla.
Georgia Podiatry Association	William J. Meadors, 306 Martin Bldg., Columbus, Ga. E. Dalton McGlamry, 603-05 Candler Bldg., Atlanta, Ga.
Hawaiian Podiatry Association	Larry M. Beers, 1037 Fort St., Honolulu, Hawaii; Stanley C. Jackola, 305 Royal Hawaiian Ave., Honolulu, Hawaii
Idaho Podiatry Association	E. J. Yacks, 722 No. 4th St., Coeur d'Alene, Idaho Charles W. Sykora, 252 N. Main St., Pocatello, Idaho
Illinois Podiatry Society	Fred G. Broun, 31 S. Pulaski Rd., Chicago, Ill. Max L. Golde, 2125 Broadway, Rockford, Ill. Douglas Durkin (Ex. Dir.), 53 W. Jackson Blvd., Chicago 4, Ill.
Indiana State Podiatrists Association	Frank C. Toepp, 531 So. Eddy St., South Bend 17, Indiana H. C. Winckelbach, 523 Merchants Bank Bldg., Indianapolis 4, Ind.
Iowa State Chiropody Association	R. E. Holdeman, 307 S.G.A. Bldg., Cedar Rapids, Iowa; C. L. Watts, Jr., 2647 Beaver Ave., Des Moines, Iowa; Rodney J. Ryan (Ex. Sec.), 411 Central National Bldg., Des Moines, Iowa
Kansas State Chiropody Association	Robert L. Wright, 4712-A East Central, Wichita, Kansas LeRoy Stucky, 2807 E. Harry, Wichita, Kansas
Kentucky Association of Chiropodists	W. B. Froehling, 809 Citizens Bank Bldg., Lexington, Ky. Chester A. Nava, 4140 Shelbyville Rd., Louisville, Ky.
Louisiana State Chiropodists' Association	Joseph Musso, 514 W. Second St., Thibodaux, La. Donald Zichichi, 1011 Pere Marquette Bldg., New Orleans, La.
Maine, Podiatry Society of	Paul Douglass, Professional Bldg., Waterville, Maine Gerald M. Rosen, 169 Main St., Biddeford, Maine
Maryland Chiropody Association	Jacob Ostroff, 3213 Greenmount Ave., Baltimore, Md. Michael Sherman, 121 W. Saratoga St., Baltimore, Md.
Massachusetts Podiatry Society	Anthony Polom, 661 Front St., Chicopee, Mass. Sidney G. Holmes (Ex. Sec.), 236 Huntington Ave., Boston, Mass.
Michigan Podiatry Association	William W. DeHart, 425 S. Grand Traverse, Flint, Mich. Bernard Levin, 14295 E. Seven Mile Rd., Detroit, Mich. Mr. Robert L. Fitzke, (Ex. Sec.), 600 N. Capitol Ave., Lansing, Mich.
Minnesota Podiatry Association	William Perendy, 217 E. Walnut St., Mankato, Minn. Robert Ray, 512 N.W. Federal Bldg., Minneapolis, Minn.
Mississippi Society of Chiropodists, Inc.	C. R. Johnson, 1 Leyser Building, Greenville, Miss. M. K. Upshaw, Jr., 511-13 Lamar Life Bldg., Jackson, Miss.
Missouri Association of Chiropodists	Kenneth E. Lane, 1207 S. Brentwood, Richmond Heights 11, Mo. C. B. Footlick, 520-22 12th & Walnut Bldg., Kansas City, Mo.
Montana Podiatry Association	L. M. Jennings, 411 First National Bank Bldg., Bozeman, Mont William Wilkinson, 510 1st Ave. No., Great Falls, Mont.
Nebraska Association of Chiropodists	L. G. Lefler, 239 W. 6th, Fremont, Nebr. Paul M. Kucera, 602 Medical Arts Bldg., Omaha, Nebr.
Nevada Association of Chiropodists	Wilbur W. Sylvester, 321 S. 5th St., Las Vegas, Nev. William A. Edwards, 150 No. Arlington Ave., Reno, Nev.
New Hampshire Podiatry Association	Arthur J. Bosa, 51 Main St., Keene, N. H. T. M. Levingston, 39 Pleasant St., Portsmouth, N. H.
New Jersey Chiropodists' Society	Mario V. Calligaro, 304 Parker Ave., Clifton, N. J. Jack Horwitz, 463 High St., Burlington, N. J.
New Mexico Podiatry Society	E. Lenore Morris, 809 Silver Ave., S. W., Albuquerque, N. Mex. C. W. Boesenberg, 922 Tijeras Ave., N.W., Albuquerque, N. M

personal contour shoes

the only shoes made by this quick, accurate and medically safe casting method



the result – the finest and most comfortable contour shoes your patients can wear

After extensive research, a new, accurate molding technique for contour shoes has been perfected. QUICK-CAST®, using a gelatinous mold completely safe to the skin, is easily performed in 15 minutes. It is neat, accurate and eliminates the heat radiation of conventional plaster which could be dangerous to diabetics.

PERSONAL CONTOUR SHOES are made from this exact casting technique. Available for men and women in six styles and 20 handsome colors. They are custom-crafted of the world's finest leathers. Personal Contour Shoes are long-wearing . . . guaranteed to fit perfectly.

Write today for color brochure

personal contour shoes

70-A Washington Street, Haverhill, Mass. U.S.A.

New York, The Podiatry Society of the State of	Milton Werbel, 55 W. 42nd St., New York, N. Y. G. Hollander (Ex. Sec.), 30 Central Park, So., New York 19, N. Y.
North Carolina Podiatry Society	Donald J. Cameron, 504 Murchison Bldg., Wilmington, N. C. Carlos T. Cooper, Jr., 303A Reynolds Bldg., Winston-Salem, N. C
North Dakota Association of Podiatrists	E. B. Snuff, 301 Black Bldg., Fargo, N. Dak. Martha Kilander, Bover Block, Minot, N. Dak.
Ohio Chiropodists Association	Henry S. Dennis, 13861½ Cedar Rd., So. Euclid, Ohio Thomas A. Crotty, 322 Wyoming Ave., Cincinnati, Ohio J. E. Farmer (Ex. Sec.), Fifty W. Broad St., Columbus, Ohio
Oklahoma Chiropody Association	Jeane L. Johnson, 510 W. Broadway, Enid, Okla. H. R. Johnson, 401 N. Beard St., Shawnee, Okla.
Oregon Podiatry Association, Inc.	George McCauley, 4126 N. E. Broadway, Portland, Ore. William V. Wheeler, 405 High St., N. E., Salem, Ore.
Pennsylvania, Chiropody Society of	Joseph D. Fletcher, 520 Temple Bldg., New Castle, Pa. Arnold W. Newman, 5411 Chester Ave., Philadelphia, Pa.
Rhode Island Podiatry Society	Edward L. Hochman, 452 Main St., Pawtucket, R. I. Leonard H. Lerner, 1045 Warwick Ave., Warwick, R. I.
South Carolina Podiatry Association	James D. Hill, 122 W. Whitner St., Anderson, S. C. H. A. McAninch, 169 Hall St., Spartanburg, S. C.
South Dakota Association of Chiropodists	M. D. Scofield, 120 W. 11th St., Sioux Falls, S. Dak. E. A. Laga, 303 Medical Arts Bldg., Watertown, S. Dak.
Tennessee Chiropody Association	Donald R. Skwor, 1306 Exchange Bldg., Memphis, Tenn. Ronald E. Fields, 524 Bennie Dillon Bldg., Nashville, Tenn.
Texas, Chiropody Society of	Ben Smith, Jr., 737 Wilson Bldg., Dallas, Tex. J. Gordon Russell, Goodhue Bldg., Beaumont, Tex. C. J. M. Roesch (Ex. Sec.), 407 Austin Savings Bldg., Austin, Tex.
Utah State Association of Chiropodists	Ralph Self, Boston Bldg., Salt Lake City, Utah Howard Jasperson, Judge Bldg., Salt Lake City, Utah
Vermont Chiropody Association	Gray S. Clark, 128 Merchants Row, Rutland, Vt. Regis P. Nolin, 14 Clarke St., Burlington, Vt.
Virginia, Podiatry Society of	Herman Chapel, New Monroe Bldg., Norfolk, Va. I. Leonard Kaplan, 718 Court St., Portsmouth, Va.
Washington State Podiatry Association	R. A. Watters, 1306 N. Eye St., Tacoma, Wash. Kurt Blau, 501 Medical Arts Bldg., Tacoma 2, Wash.
West Virginia, Chiropody Society of	Malcolm P. Iams, 716 Juliana St., Parkersburg, W. Va. G. A. Taylor, 1st Huntington Natl. Bank Bldg., Huntington, W. Va
Wisconsin Society of Chiropodists	Eugene V. Hurtienne, 2705 North 8th St., Sheboygan, Wisc. Michel M. Addis, Med. Arts Bldg., 945 N. 12 St., Milwaukee 3, Wis.
Wyoming Podiatry Society	E. O. King, 615 S. Durbin St., Casper 12, Wyo. Duane NeuSchultz, 2201 West A, Torrington, Wyo.

AFFILIATED ORGANIZATIONS

Women's Auxiliary A.P.A. (N.A.C.)—Mrs. Cleotha Parham, 5328 E. 26th St., Tulsa, Okla.
Military Association of Podiatrists—Lt. John L. Charlton, Jr., D.S.C., Podiatry Clinic, Walter Reed Army Hospital, Washington, D. C.
American College of Foot Surgeons—J. M. Kohl, 3959 No. Lincoln Ave., Chicago 13, Ill.
American Society of Chiropodical Roentgenology—Joseph L. Starr, 1115 Main St., Bridgeport, Conn.
Chiropody Bibliographical Research Society—S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa.
American College of Foot Orthopedists—Murray Bromberg, 56 Broad St., Bloomfield, N. J.
American Association of Hospital Podiatrists—H. Charles Lilienfeld, 101 W. 57th St., New York, N. Y.
American Podiatry Students Association—Bruce Wood, 296 Eureka St., San Francisco, Calif.
American Board of Chiropodical Dermatology—Joy E. Adams, Florida National Bank Bldg., St. Petersburg, Fla.

RELATED

Federation of Chiropody-Podiatry Boards—L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.
American Association of Colleges of Chiropody—Charles E. Krausz, 926 W. Lehigh Ave., Philadelphia, Pa.
National Board of Chiropody Examiners—Pierce B. Nelson, 1770 Eddy St., San Francisco, Cal.
American Academy of Chiropodists—Robert Smith, 77 James St. North, Hamilton, Ontario 10, Canada.
Academy of Podiatry—Louis Lewy, 285 Madison Ave., New York, N. Y.
American Podiatry Council—L. J. Friedman, 1186 Broadway, New York, N. Y.
Fellows Pedic Research Society—Irving M. Sward, 4948 W. Dempster Rd., Skokie, Ill.
American Foot Health Foundation—Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

Accredited Colleges

California Podiatry College
1770 Eddy Street, San Francisco, Calif.

M. J. Lewi College of Podiatry
53 East 12th Street, New York, N. Y.

Chicago College of Chiropody
1422 W. Monroe Street, Chicago, Ill.

Ohio College of Chiropody
2057 Cornell Road, Cleveland, Ohio

Illinois College of Chiropody & Foot Surgery
1327 North Clark Street, Chicago, Ill.

A new concept

STOP ITCHING HELP SKIN RESIST IRRITATION

LIDA-MANTLE T.M.

• *Relieves itching and topical pain within minutes . . ."superior to any existing local anesthetic."*[1]

• *Not a 'caine' or a 'quinoline'. Virtually non-irritating, non-allergenic, non-toxic . . . over a million uses without a single verified case of sensitization.*[2]

• *The exclusive* ACID MANTLE *vehicle soothes sensitive skin, speeds healing and wards off recurrences by rebuilding the protective barrier of acidity that helps skin resist inflammation, irritation and infection.*

Available as Creme in ½ oz. and 1 oz. tubes.
3% Xylocaine* HCl (brand of lidocaine hydrochloride) in the exclusive ACID MANTLE† vehicle.
*Reg. T.M. Astra Pharmaceutical Products, Inc. U.S. Pat. No. 2,441,498. †Reg. T.M. Dome Chemicals Inc.
1. Crawford, O. B.: Anesthesiology 14:278, 1953. 2. Wiedling, S.: Xylocaine, The Pharmacological Basis For its Clinical Use, Stockholm, Almquist and Wiknell, 1959.

DOME
WORLD LEADER IN DERMATOLOGICALS
DOME CHEMICALS INC.
New York Los Angeles

STATE BOARD MEETINGS
FOR EXAMINATION AND LICENSURE

Alabama

The Alabama Medical Board of Examiners. **Board Secretary:**

Arizona

Arizona State Board of Chiropody Examiners. **Board Secretary:** Martin Snyder, D.S.C., 2629 E. Broadway, Tucson, Ariz.

Arkansas

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California

The California Chiropody Examination Committee will meet for examination tentatively Aug. 22-23, 1961 in Los Angeles; June 20-21, 1961 in San Francisco; Oct. 17-18, 1961 in Sacramento. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento 15, Calif.

Colorado

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut

The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dover, Dela.

District of Columbia

The Board of Podiatry Examiners of the District of Columbia will meet for examination July 11, 12, 1961 at the Dept. of Occupation and Professions, Wash., D. C. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia

The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee will meet for reciprocity June 14, and examination June 14-16, 1961 at 160 No. LaSalle St., Rm. 201, Chicago, Ill. (Applications for examination must be on file at Dept. of Registration & Education, Rm. 112, State House, Springfield, Ill., at least 15 days prior to date of examination.) **Superintendent of Registration:** Fredric B. Selke, Room 109, State House, Springfield, Ill.

Indiana

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa

The Iowa State Board of Chiropody Examiners will meet for examination June 5-7, 1961 at the State Office Bldg., Des Moines, Iowa. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville 7, Ky.

Louisiana

Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Robert M. Quinn, D.S.C., 16 South St., Pittsfield, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners will meet for examination June 15, 16, 1961 at the State Capitol, St. Paul, Minn. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody will meet April 28, 1961 in Jefferson City, Mo. **Board Secretary:** Frank Fulkerson, 611 Clay St., Chillicothe, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nev.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry will meet for examination July 15-16, 1961. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York

The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

CARBOCAINE® hydrochloride

(Brand of mepivacaine hydrochloride)

a unique local anesthetic with "...outstanding features."[1]

Carbocaine combines the best characteristics of older local anesthetics with exceptional new advantages.

More potent
than procaine or lidocaine.[2]

•

Quicker onset of anesthesia
than obtained with other agents.[3]

•

More prolonged anesthesia
— lasts several hours.[1,4]

•

Greater safety
—low toxicity, virtually no vasodilatation,[1,5] epinephrine not required except for hemostasis.

•

Local anesthesia extended
to many more patients and procedures.[4,5]

•

Greater stability
—no risk of decomposition or loss of potency.

Carbocaine has been found suitable for elderly or poor risk patients, for patients with epilepsy or cardiac disease, as well as for many others in whom potent anesthetics are generally contraindicated.

For infiltration and nerve block, caudal and peridural block, and therapeutic block in management of pain.

How Supplied: For infiltration and nerve block: Carbocaine hydrochloride, 1 per cent and 2 per cent, in sterile saline solution, in multiple dose vials of 50 cc. For caudal and peridural block: Carbocaine hydrochloride, 1 per cent, in sterile modified Ringer's solution, in single dose vials of 30 cc.

References: 1. Sadove, M. S.: A preliminary report on Carbocaine, a new local anesthetic. Submitted for publication. 2. Luduena, F. P.; Hoppe, J. O.; Coulston, F., and Drobeck, H. P.: The pharmacology and toxicology of mepivacaine, a new local anesthetic, *Toxicol. & Appl. Pharmacol.* To be published. 3. Rovenstine, E. A.: Personal communication. 4. Young, J. A.: Upper arm block with Carbocaine (mepivacaine), a new anesthetic agent, *Anesth. & Analg.* To be published. 5. Griesser, Gerd: Erfahrungen mit einem neuen Lokalanestheticum, *Anaesthesist* 6:364, Oct., 1957.

Winthrop Laboratories
New York 18, N. Y.

Carbocaine (brand of mepivacaine), trademark reg. U. S. Pat. Off.

State Board *(Cont.)*

North Carolina

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody will meet for examination when necessary, in June and September and other times as needed. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners will meet for examination in July, 1961, at the Education Bldg., Harrisburg, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina

The South Carolina Board of Podiatry Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Viola Marr, 115 N. Main Ave., Sioux Falls, S. D.

Tennessee

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

Texas

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Tex.

Utah

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Russell M. Cox, M.D., 509 Professional Bldg., Portsmouth, Va.

Washington

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

Wyoming

The Wyoming State Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.

Have You Sent in Your Contribution and-or Pledge

Our goal is $100 from each member of the profession.

Enclosed is my contribution of $_____ to the Fund for the Advancement of Podiatry (Chiropody) Education.

I wish to ANNUALLY pledge $_____ to the Fund.

Bill me Annually ( ) Semi-annually ( ) Quarterly ( )

I wish my donation designated for:

( ) The General Fund, for all schools.

( ) Earmarked for _____ Podiatry Chiropody College.

Name _____

PLEASE PRINT

Street Address _____

City _____ State _____

FUND FOR ADVANCEMENT OF PODIATRY-CHIROPODY EDUCATION

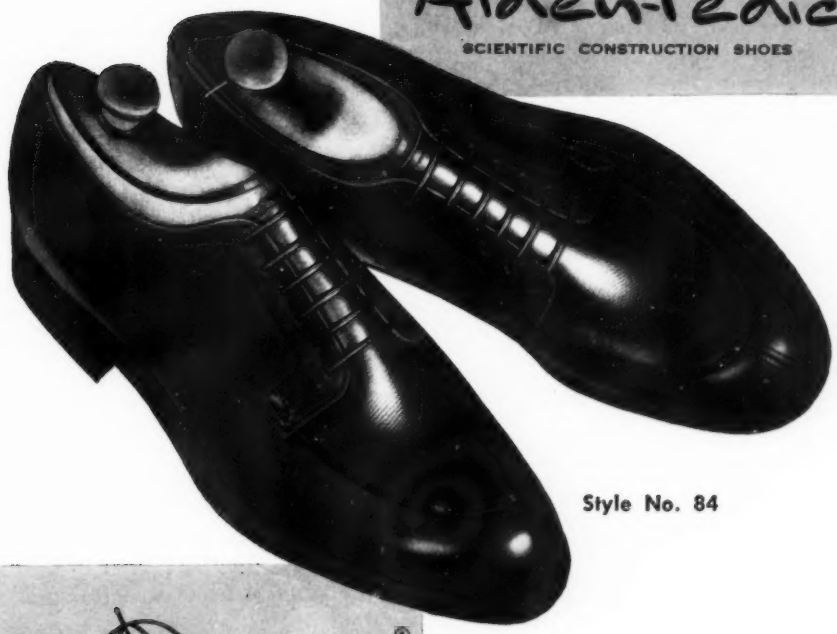
3301 16th Street, N. W.

Washington 10, D. C.

THE MOST
MODERN APPROACH
TO FOOT PROBLEMS

Alden-Pedic

SCIENTIFIC CONSTRUCTION SHOES



Style No. 84

FOOT BALANCE®

SHOES AND LASTS
SERVE 3 PURPOSES

✓ LASTS DESIGNED TO FIT INDIVIDUAL FOOT TYPES
✓ ACCOMMODATE PRESCRIBED CORRECTIONS
✓ PROVIDE A STABLE CONTROLLED FOUNDATION

Progress Through Research

C.H. ALDEN SHOE COMPANY

Custom Bootmakers Since 1884

BROCKTON, MASSACHUSETTS

WRITE TODAY
FOR OUR PROFESSIONAL
CATALOG AND NAME OF
YOUR NEAREST DEALER.

"The Convention of Distinction"

REGION 3. CHIROPODY SCIENCE CONCLAVE

(Delaware, Maryland, New Jersey and Pennsylvania)

APRIL 27, 28, 29 and 30, 1961

AMBASSADOR HOTEL ATLANTIC CITY, N. J.

A Program of Timely Information on Current Chiropodical Problems

FEATURED PRESENTATIONS

Symposium on Case Presentation and Patient Orientation

Joseph D. Fletcher, D.S.C., New Castle, Pa. ....."Orientation of Pediatric Patient"
Wallace Beylin, D.S.C., Akron, O. ....."Orientation of Adult Patient"
H. C. Collins, D.S.C., A.C.F.S., Columbus, O. ....."Orientation of Surgical Patient"

Written Questions Will Be Considered by the Panel

James A. Conforti, D.S.C., Bedford, O. ....."Industrial Chiropody"
A Practically Unexplored Field Offers New Opportunities

Novelty Combination—A Region 3. "First"
"Lunch and Learn"

Personal Selection Invited from Among the Following Authorities:
Milton E. Ashur, D.S.C.—"Medicine in Chiropody"; James E. Bates, D.S.C.—"Roentgen Diagnosis"; Wallace Beylin, D.S.C.—"Adult Patient Control"; Malcolm Brahms, D.S.C.. M.D.—"Related Chiropodical Orthopedic Subjects"; H. L. Collins, D.S.C.—"Surgical Patient Control"; James A. Conforti, D.S.C.—"Industrial Chiropody"; Bernard C. Egerter, D.S.C.—"Practice Management"; Joseph D. Fletcher, D.S.C.—"Pediatric Patient Control"; Jonas C. Morris, D.S.C.—"Practice Management—The New Office"; Louis Newman, D.S.C.—"Surgical Procedures"; Max Pomerantz, M.D.—"Ankle Edema."

Advance registration and three selections in order of preference must be sent to Dr. Jacob J. Ostroff, 3213 Greenmount Ave., Baltimore, Maryland.

Special Feature

ARTHUR SECORD, M.A., Ph.D., Brooklyn, N. Y.
Internationally Known Authority on Speech Communication and Human Relations
"HOW TO TELL WHAT YOU KNOW"

Nicholas Mauriello, M.D., Philadelphia, Pa.
"Rheumatic Syndrome of the Lower Extremities—Physiatrist's Viewpoint"

J. P. Gray, M.D., Detroit, Mich.
"Communications in Medicine—On Writing Professional Articles"

Louis Newman, D.S.C., A.C.F.S., Philadelphia, Pa.
"Semantics and Insurance Forms in Reference to Foot Surgery"

Seward Nyman, Ass't. Secretary, A.P.A.
"Report on Current Progress and Future Objectives of Our National Organization"

Anthony Sindoni, M.D., Philadelphia, Pa.
"The Geriatric Diabetic"

Leonard Zimmerman, LL.B., Poughkeepsie, N. Y.
"The Chiropodist and Liability"

S. Regen Ginsberg, LL.B., Philadelphia, Pa.
"Chiropodical Jurisprudence"

Malcolm Brahms, D.S.C., M.D., A.C.O.S., Cleveland, O.
"The Orthopedist Looks at Chiropody"

Registration $10.00. Mail check or money order to Dr. James C. White, 119 Federal Street, Milton, Delaware.

Rx EDWARD'S PRESCRIPTION SHOES

FOR ADULTS ONLY

Shoes should be an important part of your practice. If you are shoe minded, our plan of servicing your patients in your office should be of utmost interest to you. You can dispense EDWARD'S PRESCRIPTION SHOES for men and women without carrying a stock of shoes, and without an investment.

For more than 36 years, thousands of your fellow practitioners have used EDWARD'S PRESCRIPTION SHOES for adults as an adjunct for treating the various forms of foot disabilities. The fit is guaranteed. Shoes may be returned either for exchange or refund.

SHOES SUPPLIED ON INDIVIDUAL PRESCRIPTIONS

Write for our beautifully illustrated catalog and our plan to dispense shoes in your office — on your professional stationery please.

THE SATISFACTORY SHOE CO.

7 W. WASHINGTON STREET, CHICAGO 2, ILL.

COUNCILS and COMMITTEES

COUNCIL ON EDUCATION

F. S. Schwarz, Chairman, 1825 5th Ave., Troy, N. Y.; I. Yale, Vice Chairman, 364 E. Main St., Ansonia, Conn.; P. R. Brachman, Secretary, 25 E. Washington St., Chicago, Ill.; E. N. Barron, 900 W. 4th St., Little Rock, Ark.; Milton H. Gennis, 1432 S. Peoria Ave., Tulsa, Okla.; R. K. Locke, 142 Engle St., Englewood, N. J.; P. B. Nelson, 1675 E. 14th St., San Leandro, Calif.; Max Pomerantz, M.D., 2057 Cornell Rd., Cleveland, Ohio; E. L. Tarara, Mayo Clinic, Rochester, Minn.; G. R. Tobin, 153 3rd Ave., N., Twin Falls, Idaho.

CONSTITUTION AND BY-LAWS COMMITTEE

LeRoy C. Numbers, Chairman, 1327 N. Clark St., Chicago, Ill.; Joy E. Adams, Florida, National Bank Bldg., St. Petersburg, Fla.; Joseph D. Fletcher, 520 Temple Bldg., New Castle, Pa.

DIVISION OF EXTERNAL AFFAIRS

Benjamin C. Mullens, Director, Security Mutual Bldg., Binghamton, N. Y.

Council on Public Education and Information

James A. Conforti, Chairman, 767 Broadway, Bedford, Ohio; Edward H. Bier, 417 Washington St., Hoboken, N. J.; H. L. Collins, 318 E. State St., Columbus, Ohio; J. E. Green, 108 Murray St., Binghamton, N. Y.; S. S. Rudnick, 229 Main St., West Haven, Conn.

Council on Extra-Professional Relations

Earl G. Kaplan, Chairman, 14608 Gratiot Ave., Detroit, Mich.; N. C. Bianco, First Central Tower, Akron, Ohio; J. A. Conforti, 767 Broadway, Bedford, Ohio; L. E. Johnson, 4346 Degnan Blvd., Los Angeles, Calif.; A. G. Kalin, 24453 Grand River Ave., Detroit, Mich.; E. F. Weiner, 450 7th Ave., New York, N. Y.

Council on Allied Health Relations

Ralph E. Owens, Chairman, 1700 Exchange Blvd., Oklahoma City, Okla.; Clarence Bookbinder, 319 W. Broad St., Burlington, N. J.; George E. Guenzler, 104 Professional Bldg., Freeport, Ill.; H. H. Johnson, 510 W. Broadway, Enid, Okla.; L. G. Lefler, 329 W. 6th St., Fremont, Neb.; David Simon, 2992 Bailey Ave., Buffalo, N. Y.; Edward Tornow, 6135 Wilshire Blvd., Los Angeles, Calif.

DIVISION OF INTERNAL AFFAIRS

Joy E. Adams, Director, Florida National Bank Bldg., St. Petersburg, Fla.

Council on Professional Information

William A. Edwards, Chairman, 150 No. Arlington Ave., Reno, Nev.; B. C. Egerter, 507 Liberty Ave., Pittsburgh, Pa.; H. Feinberg, 1680 Meridian Ave., Miami Beach, Fla.; Chester Nava, 4140 Shelbyville Rd., Louisville, Ky.

Council on Membership Development

Harry I. Horowitz, Chairman, 80-96 Steinway St., Astoria, L. I., N. Y.; S. O. Burgess, 17189 Schaefer, Detroit, Mich.; J. C. Pankratz, 275 North St., Meadville, Pa.; I. Pashin, 12 Catharine St., Poughkeepsie, N. Y.

Council on Scientific Sections

L. B. Thompson, Chairman, 5613-7th Ave., Kenosha, Wisc.; M. Bromberg, 56 Broad St., Bloomfield, N. J.; W. F. Eads, 1651 Garnet St., San Diego, Calif; K. C. Nielsen, City National Bank Bldg., Omaha, Neb.; Richard O. Schuster, 14-15 160th St., Whitestone, L. I., N. Y.; Irving Yale, 364 E. Main St., Ansonia, Conn.

DIVISION OF SPECIAL AFFAIRS

Robert Shor, Director, 4480 Crenshaw Blvd., Los Angeles, Calif.

Audio-Visual Council

Marvin W. Shapiro, Chairman, Toledo, Ohio; W. L. Beylin, Akron, Ohio; M. M. Greenfield, Toledo, Ohio; C. S. Kaczmark, Toledo, Ohio; Robert Weinstock, Detroit, Mich.; George Dame, Secretary, 3301 16th St., N. W. Washington, D. C.

Council on Podiatry Therapeutics and Pharmacy

Harry L. Hoffman, Chairman, 1098 National Press Bldg., Washington, D. C.; F. N. DiGilio, Skokie, Ill.; A. V. Johnson, Midland, Tex.; E. C. Meldman, Milwaukee, Wisc.; S. Moskow, Washington, D. C.; R. E. Owens, Oklahoma City, Okla.

Council on Foot Wear

Edward C. Meldman, Chairman, 161 W. Wisconsin Ave., Milwaukee, Wisc.

SPECIAL COMMITTEES

Children and Youth Fitness—John T. Sharp., 2002 Woodland Rd., Abington, Pa.

Aging—Edward L. Tarara, Chairman, Mayo Clinic, Rochester, Minn.; Robert A. Giudice, 118 S. W. 4th Ave., Gainesville, Fla.

Nomenclature—Peter N. Varzos, 25 E. Washington St., Chicago, Ill.

Farm Foot Health—Ralph C. Kirkwood, Kresge Bldg., Des Moines, Iowa.

Advisory Committee on Civil and Defense Emergency Medical Care—Arthur E. Helfand, St. Luke's and Children's Medical Center, Franklin and Thompson Sts., Philadelphia, Pa.

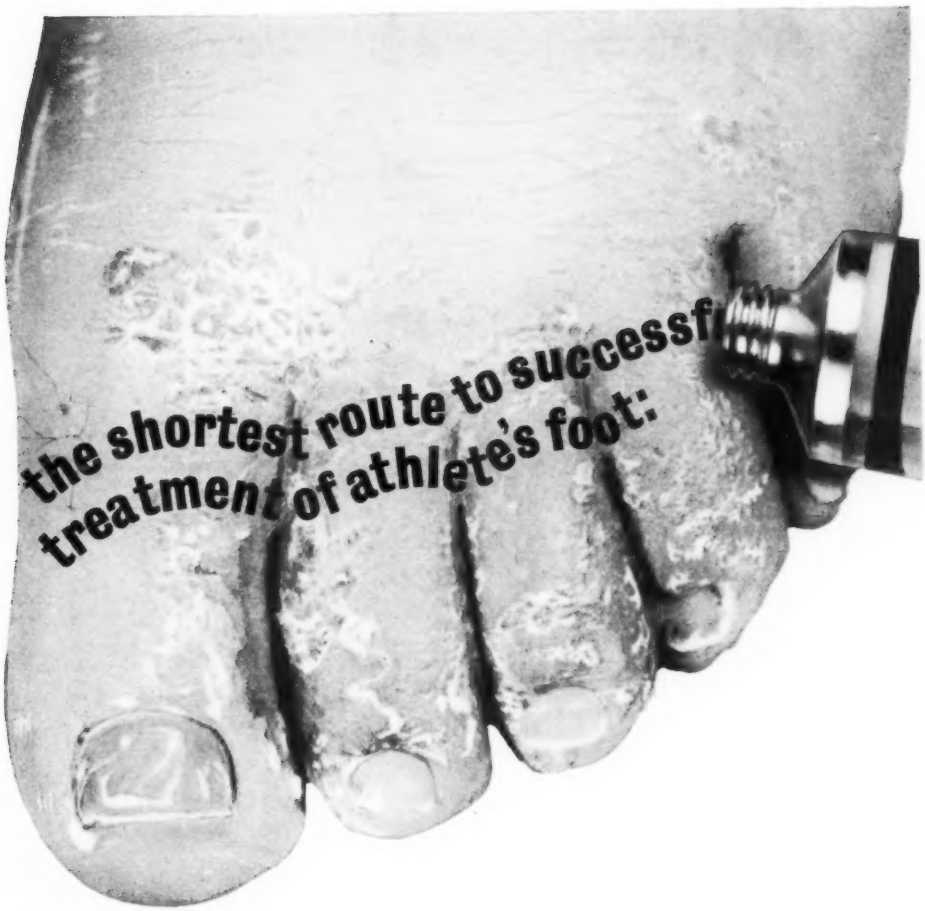
Medical Liaison—George Guenzler, Chairman, 104 Professional Bldg., Freeport, Ill.; Marvin Shapiro, Toledo, Ohio; Douglas T. Mowbray, Waterloo, Iowa; A. Rubin, Secretary, 3301 16th St., N. W., Washington, D. C.

FEDERAL AFFAIRS ADVISORY COMMITTEE

Charles Turchin, 818 18th St., N. W., Washington, D. C.

COMMITTEE ON ARRANGEMENTS 1961 ANNUAL MEETING

Seward P. Nyman, Convention Manager, 3301 16th St., N. W., Washington, D. C.; Edward B. Hurd, 623 Dupont Bldg., Miami, Fla., and Herbert Feinberg, 1680 Meridian Ave., Miami Beach, Fla., General Co-Chairmen.



Athlete's foot is caused by fungi invading the horny, keratinized layers of the skin not reached by the normal blood supply. Topical application of DESENEX, a combination of zinc undecylenate and undecylenic acid, brings these powerful antifungal agents into direct contact with troublesome fungi and quickly relieves—**and arrests**—the annoying condition.

Hundreds of thousands of athlete's foot infections have been arrested by topical treatment with DESENEX, among the best tolerated of all potent fungicidal agents.

And DESENEX is inexpensive—only pennies per treatment: DESENEX Ointment can be applied liberally to both feet every night for a week and a half from only a single tube. Itching and discomfort are stopped almost immediately. DESENEX is also recommended for treatment of other susceptible fungus infections of the skin and nails.

Dosage: At night, supply Ointment liberally to infected and surrounding areas. In the morning, rub or shake powder into the shoes and feet.

Supplied: Ointment—1 oz. tubes and 1 lb. jars. Powder—1½ oz. and 1 lb. containers. Solution (Undecylenic acid)—2 fl. oz. and 1 qt. bottles. Aerosol Spray—6 oz. cans.

Maltbie Laboratories Division,
Wallace & Tiernan Inc., Belleville 9, N. J.

Desenex®
ointment • spray
powder • solution

Available in Canada through Elliott-Marion Company, Ltd., Montreal. PD-11

BEFORE

You Look Elsewhere

CHECK

Your A.P.A. Insurance Program First

Thousands of Podiatrists Have Found Their APA Insurance Plans to be

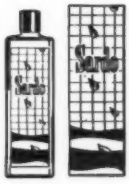
"Just What the Doctor Ordered"

$10,000
MAJOR
MEDICAL PLAN

for members and their families

- In Hospital—Home—Doctor's Office
- Physicians' and Surgeons' Fees
- Graduate Nurses' Fees
- Hospital Charges
- Blood—X-Rays—Oxygen—Medication—Ambulance—Etc.

new clinical study[1] cites marked improvement in over 80% of cases in dry, itchy, fissured skin with Sardo®



Use of SARDO in 79 podiatry patients with conditions marked by dry, itchy, scaly, fissured or eczematoid skin achieved these excellent results:

CASES	AFTER SARDO*
18 Tineal Fissured Heels	Marked Improvement
30 Diabetics	Marked Improvement
3 Pompholyx	Moderate Improvement
8 Eczematoid Dermatitis	Marked Improvement
12 Radiation Dermatitis	Slight Improvement
8 Non-specific Dryness and Scaliness	Marked Improvement

SARDO acts[1-3] to (A) restore the normal protective acidity of the skin, (B) lubricate and soften, (C) replenish natural emollient oil, (D) prevent excessive evaporation of moisture.

SARDO releases millions of microfine water-dispersible globules to provide a soothing suspension which enhances the efficacy of your other therapy.

SARDO is pleasant, convenient, easy to use; non-sticky, non-sensitizing. Most economical. Bottles of 4, 8 and 16 oz.

1. Steinberg, M.D.: J. Amer. Podiatry Assn., June 1960.
2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.
3. Prentice, H. and Brezak, S.: J. Amer. Podiatry Assn., May 1958.

for SAMPLES and complete reprint of Steinberg paper, please write...

*patent pending T.M. ©1960 *Sardeau, Inc.* 75 East 55th Street, New York 22, N. Y.

For the patient with onychomycosis

Onycho-Phytex®

can unlock the door to successful treatment...

by a three-fold attack essential for effective control:

penetrating vehicle— that reaches the fungi in deep keratin layers.

multiple antimycotic action—in vivo— 1) kills fungi by direct tanning action, 2) lowers local pH, 3) inhibits local sweat production.

prolonged action— sustained release medication film provides continuous 12-hour antifungal action.

But—the door to success opens wide *only* when ONYCHO-PHYTEX is combined with:

■ *Thorough and regular debridement* (in your office) of affected nails by chemical or mechanical means, to remove piled-up horny growth.

■ *Conscientious patient cooperation* at home in carrying out the twice daily application schedule for an adequate period. Visible improvement (healthy new nail growth) should not be expected for several months. Patient instruction sheets are available to you on request as an aid in gaining long-term cooperation.

Formula: each cc. contains

Borotannic complex (derived from: Tannic acid 46 mg., Boric acid 29 mg.) ..... 75 mg.
Salicylic acid ..... 8 mg.
Ethyl alcohol (by volume) 56%

Supply: In bottles of 15 cc. and 30 cc. with brush in cap—on prescription only.

WYNLIT PHARMACEUTICALS, INC., MADISON, NEW JERSEY WYNLIT

POLYSORB® HYDRATE

a balanced water-in-oil emulsion

WHEN A LOTION IS PREFERRED
NEW
POLYSORB® HYDRATE LOTION

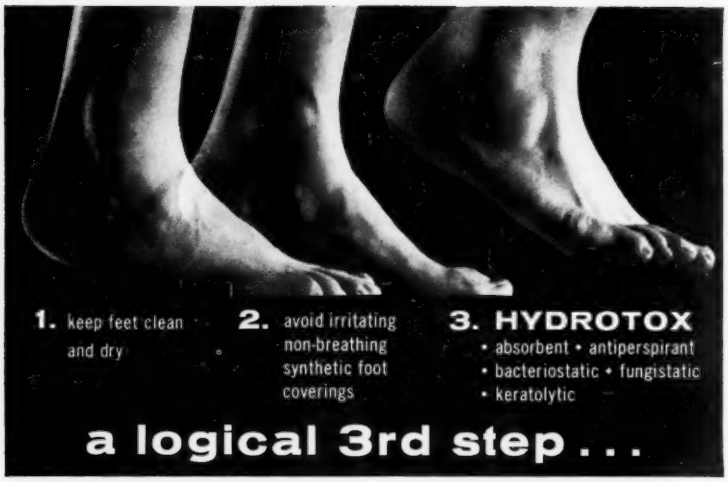
Only a water-in-oil emulsion provides the optimum protection against dry skin

. . . Water is the answer to dry skin, and only POLYSORB HYDRATE offers a continuous release of water for tissue rehydration. POLYSORB HYDRATE also provides prolonged emollient and protective action for the deeper cells. It is bland, non-sensitizing, non-irritating . . . your answer to dry skin and other disorders of the skin of the foot to which it may lead.

Available 50 gr. tube and 425 gr. jar. Samples on request.

E. Fougera & Company, Inc., Hicksville, Long Island, N. Y.

FOUGERA


1. keep feet clean and dry
2. avoid irritating non-breathing synthetic foot coverings
3. HYDROTOX
• absorbent • antiperspirant
• bacteriostatic • fungistatic
• keratolytic
a logical 3rd step . . .

for prevention and control of fungal and ringworm infections of the feet

hydrotox®

. . . is a balanced formula of widely useful components for the treatment and prophylaxis of common superficial fungal infections. A highly useful adjunct in maintaining conditions unfavorable to continued proliferation of fungi, HYDROTOX is soothing, non-irritating, non-sensitizing, and non-abrasive. Administration: Control and treatment of fungal infections require two entirely different products and formulae which are available to your patients with HYDROTOX.

Hydrotox Dry Spray Powder is applied liberally in the morning to infected and adjacent areas, and to socks and shoes as a precaution against re-contamination.

Hydrotox Ointment is applied at bedtime to infected and adjacent areas.

Send for FREE informative brochure on fungus infections.

Formulae and Supply:

Hydrotox Dry Spray Powder is supplied in a 3 oz. plastic bottle containing the following active ingredients: Salicylic Acid 2.0%, Zinc Stearate 3.0%, Boric Acid 6.0%, Alum, exsiccated 1.0%.

Hydrotox Ointment is supplied in a 1½ oz. heat-sealed tube containing the following active ingredients: Hexachlorophene 0.3%, Precipitated Sulfur 3.0%, Salicylic Acid 3.0%, Undecylenic Acid 2.5%.

©1961

ZOTOX PHARMACAL COMPANY, Inc., Stamford, Connecticut

WHAT IS THE MOST COMMON CHILDREN'S FOOT PROBLEM... PRONATION?

THIS SHOE IS DESIGNED TO MEET YOUR PRESCRIPTION REQUIREMENTS

For maximum adaptability in a *quality* shoe, examine **Edwards** CorecTreds. Long molded inside counters, steel shanks built into the soles, and special lasts for ample tread and toe room give CorecTreds the value distinction typical of *every* **Edwards** shoe.

Mild or extreme pronation, supination, pigeon-toe, or pre- or post-operative needs — *whatever* your prescription, there's an **Edwards** shoe to meet its requirements.

Examine and advise CorecTreds and Pedics by **Edwards**!

Edwards
THE SHOE FOR CHILDREN

PHILADELPHIA 7, PA.

CORECTREDS—FOR MILD DISORDERS

PEDICS—FOR SEVERE DISORDERS

FREE

EDWARDS NEW PEDIC KIT

Now, receive Edwards new, complete Pedic Kit designed especially for you. It contains:

- **WEDGE CHART**
- **PEDICGRAPH**
- **PRESCRIPTION PADS**
- **CORECTRED FOLDERS**
- **PEDIC BROCHURES**
- **HAPPY FEET BOOKLET**

Simply Detach This Portion of Advertisement, Mail With Your Personal Letterhead to Edwards Shoes, 314 N. 12th St., Phila. 7, Pa.

DAY DATE

90% of the patients you see each day suffer from conditions for which **Podiacort** is a specific!

TIME	NAME	OFFICE DATA
9:00	Raoul Eric[illegible]	Varicose eczema ✓
9:30	Theo Martin	Trophic ulcer ✓
10:00	Raymond Butler	Fit corrective brace
10:30	Harriet Nelson	Inflamed nail grooves ✓
11:00	Elmer Spoff	Shoe dermatitis ✓
11:30	Ed Dunn	Callus ✓
12:00	P.M.	
1:30	James Taylor	[illegible]dema ✓
2:00	Allen Jackson	Ro[illegible] [illegible]xamination
2:30	Edith Ramont	Varic[illegible]er ✓
3:00	Rita Wilbourne	Stasis [illegible]is ✓
3:30	Jess Sweem	[illegible]ergic e[illegible]
4:00	Myrtl[illegible]	[illegible]p care ✓
4:30		
5:00		
5:[illegible]		
6:[illegible]		
7:00		
7:30		
8:00	Filip[illegible]	
8:30	Carol Johnson	Infection(secondary) ✓

Podiacort Ointment . . .

for potent anti-inflammatory/antibacterial/antifungal action whenever pain, soreness and infection are a present or potential problem in foot therapy.

EACH 1 GM. PODIACORT OINTMENT CONTAINS:

Podiacort (Podiatrex Ltd. brand of hydrocortisone diethylaminoacetate hydrochloride) 5. MG.
Neomycin sulfate (as the base) . . . . . 3.5 MG.
Undecylenic acid . . . . . 50 MG.

In a highly refined, cosmetically elegant petrolatum base.

Administration and Dosage: Apply to affected areas one to four times daily, or as directed

Supply: Podiacort is available in 5 and 15 gm. tubes—on prescription only at prescription pharmacies across the country.

PodiatRex GLENDALE 1, CALIFORNIA LTD.

Serving the Podiatrist exclusively

JOURNAL
OF THE
AMERICAN PODIATRY
ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

VOLUME 51 MARCH 1961 NUMBER 3

Retarded Osseous Development as a Primary Factor in Weakfoot*

Joseph R. Cinzio, D.S.C., F.A.C.F.O.
Passaic, N. J.

THE prevalence of retarded osseous development in children has served as a stimulus for this paper. Originally the author was first confronted with this particular entity in chiropody college. It has demonstrated itself on numerous occasions in private practice. The specific etiology remains unknown, but predisposing or contributing factors will be enumerated. An attempt will be made to show a relationship between retarded osseous development and weakfoot in children.

Brachman[1] states that "too much attention has been directed towards physical age in children in relation to the development of the feet. In thinking of the physical age we may be confronted with the possibility of seeing a child who is 6 years old chronologically, but who is less than 4 years old from a foot development and foot functional standpoint."

Dickson[2] in his book on posture says that nearly 20 percent of all adults develop visceroptosis. This was generally seen in the asthenic individual, long boned and rather thin and tall. Brachman believes that this type of individual is in most respects the adult picture of the child with this physical development. Statistics to link these two entities have not been recorded. However, our present understanding of postural unbalance, its etiologies and its development, leads us to the same conclusion. It would seem that if these findings are discovered during childhood and remedied by appropriate measures, many postural difficulties in the adult could be avoided.

Many physicians have been advising parents that their children will "outgrow" foot difficulties. Some pediatricians and general practitioners who are aware of the long-range problems associated with faulty weightbearing in childhood, seek to correct these deficiencies. As podiatrists, we must be ready to point out these defects to all.

Bone Development

In the field of podopediatrics it is essential that the podiatrist have some knowledge of bone fusion, as well as primary and secondary ossification centers in order to fully comprehend each particular case. Table I is presented to serve the foot specialist's needs. The author refers the reader to Todd's "Atlas of Skeletal Maturation"

*Paper awarded Honorable Mention in the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1960. Presented at the Annual Meeting of the A.P.A. held at the Drake Hotel, Chicago, Ill., August 1960.

TABLE I

Pediatric Chart of Bone Development

Bones	Primary Appears	Secondary Appears	Fuses
1—Calcaneus	4-7 F.M.-1M.	5-12 yr.	12-22 yr.
a. Apophysis		11 M.	17 yr.
2—Talus	4-8 F.M.-2M.		
3—Navicular	3M. to 5 yr.		
4—Cuboid	6 F.M.-1 yr.		
5—Cuneiforms			
First	9M.-4 yr.		
Second	9M.-5 yr.		
Third	9 F.M.-4 yr.		
6—Metatarsals	2-4 F.M.	6-24 M.	13-22 yr.
7—Phalanges			
Proximal	2-4 F.M.	6-24 M.	12-22 yr.
Middle	10 F.W. to 7 yr.	9-24 M.	12-22 yr.
Distal	2-4 F.M.	1-2 yr.	12-22 yr.
8—Tibia	6-12 F.W.	2 yr.	18-19 yr.
a. Upper end	Birth	4 M.	18-19 yr.
b. Lower end	2 yr.	4-6 M.	19 yr.
9—Fibular	6-10 F.W.	5-13 M.	
10—Femur	6-12 F.W.		18-19 yr.
a. Greater trochanter	6-12 F.W.	3-5 yr.	18 yr.
b. Lesser trochanter	4-12 F.W.	14 yr.	18 yr.
c. Lower end	Birth		

F.W.—Fetal Weeks. F.M.—Fetal Months. M—Post-Natal Months.
(Modified from Sante's Principles of Roentgen Interpretation, 8th Edition)

and Caffey's "Pediatric X-ray Diagnosis" for more complete charting of skeletal growth.

The tarsal, metatarsal and phalangeal bones all originate from primary centers of ossification and continue to mature until the secondary centers of the os calcis and metatarsal and phalangeal bones appear; then union of the primary and secondary centers takes place with subsequent completion of ossification.

The normal maturation of the bones of the feet in girls as compared to boys is about 1½ years until the age of puberty. In routine examinations of the pediatric patient, the author utilizes X-rays of the wrists along with the standard views of the feet. Radiographs of the wrists and hands offer the best guide for determining the skeletal age of the patient. In 4 of the 12 cases presented in this study, retardation of the carpal and midtarsal regions existed simultaneously. Hip X-rays of these four cases revealed normal skeletal development.

Factors Affecting Growth

Throughout the period of growth, there is a constant change in its relative composition. Stearns[4] has thoroughly reviewed the mineral changes in the fetal and infancy periods, but only inferential and fragmentary data is available thereafter. The matter is of clinical importance, however, if the clinician is called upon for an appraisement of the growth process and its abnormalities.

Height and weight reflect the process of growth inadequately, giving only suggestive information of the qualitative changes in tissues until these are extreme, though it is true that in time a negative balance for a basic substrate will prove incompatible with continuous normal growth of the entire body. Information of this type is at present obtainable only by balance studies in which the intake of the substance and its loss in the stools and urine are determined, an obviously impractical clinical procedure, but essential for basic data.

X-ray studies of the bone structure are qualitative and serve as a guide to the clinician.[5]

One of the commonest problems presented to the pediatrician for explanation and management is that of retarded and advanced growth. The podiatrist may be confronted with a phase of either of these entities. This discussion will restrict itself to retarded growth as seen in the foot.

Heredity

The basic determinants of growth and development are inherited and to a large extent immutable. Geneticists have explored individual items such as height and weight. Little and Macy have done extensive surveys on both of these factors.[6]

It should be pointed out that in a broad sense, economic circumstance is one of the largest single factors determining growth and development. The major difficulty, in a selected group of patients, lay in the presence of organic disease interfering with the utilization of the normal diet.[3]

Infection

An acute febrile process of short duration produces a deficit which can be quickly repaired; in fact, the avidity with which tissues retain items which have been depleted is one of the characteristics of the recovery from disease. Less evident is the impairment of growth by a chronic focus of infection which may not give rise to fever.[3]

Endocrine Glands

Growth and development are so intimately linked with the endocrine system, that neither can proceed normally in the presence of a defect in the production of a number of the hormones, nor does there occur an isolated defect in one of the glands of internal secretion without a concomitant alteration in the others.

a. **Pituitary:** Gigantism and acromegaly are both established as associated with hyperactivity of the anterior lobe. The clinical problem posed by a generalized retardation of growth should include a consideration of lesions of the anterior lobe. Whether a local retardation of bone growth is related to pituitary dysfunction, remains to be explored.

b. **Thyroid:** The role of this gland in affecting growth and development is firmly established. The retardation of growth accompanying the hypothyroid state is characterized by an inability to retain both nitrogen and calcium, but negative balances for both of these items are seen in hyperthyroidism also. Mild degrees of the latter state show accelerated growth, the result of an increased anabolism generally. When the problem of retarded growth or development presents itself in the younger age groups, in whom metabolism determinations are not feasible, wrist radiographs have been found to be of great value in the assessment of skeletal age. Others have stressed the usefulness of measuring phosphatase and cholesterol.

c. **Parathyroid:** The normal function of the parathyroid gland is to exert control over the metabolism of calcium and phosphorus, which is essential to normal growth and development.

d. **Adrenal:** Absence of the cortical hormone, as in Addison's disease, carries with it a failure to retain not only electrolyte, but nitrogen, and is incompatible with normal growth and development. Johnson[3] reported that the administration of cortical extract in one case promptly reversed a negative nitrogen balance and, in addition, menarche appeared.

e. **Sex Hormones:** Essential to the differentiating aspect of growth, a specialized function, these may be said, in a sense, to be antagonistic to skeletal growth, as is evident from the striking correlation between the menarche in girls and the abrupt depression of growth in height.

f. **Pineal Gland:** This has been implicated as causative agent in sexual precocity with skeletal retardation.

Minerals

All of the tissues of the body require an adequate supply of minerals for their struc-

ture and function. As regards to mineral needs for infants and children, a proportionately larger quantity is needed than in adult life, not only because of the demands of greater growth and activity, but because disease processes and environmental factors are more likely to take a greater toll of a child's mineral resources.[4] As a rule, the basic diet of a normal child furnishes adequate amounts of all of the essential minerals, and for the most part in a form favorable for absorption and utilization.

Let us briefly consider the minerals of greatest practical importance in human nutrition. Of primary consideration are sodium and chlorine which constitute the major mineral portion of the extracellular fluid compartment of the body, there being in this compartment but small increments of potassium, calcium, magnesium, phosphorus and protein. In contrast to the extensive sodium and chlorine storage in the extracellular fluid compartment, the potassium, magnesium and phosphorus are chiefly stored in the intracellular compartment.

In clinical practice this information is of importance since it is in the acute states of dehydration and acidosis that major alterations occur in the extracellular compartment and involve chiefly sodium, chlorine and water. If the state is severe and involves tissue destruction as serious alteration, the interstitial fluid compartment and finally the intracellular compartment are altered greatly. In such a case, the metabolism of potassium and, to a lesser extent, phosphorus are involved.

Calcium is essential for the formation and maintenance of the skeleton and of the teeth. It must be present and in equilibrium with sodium and potassium for proper regulation of nervous irritability and for heart contractility. According to Davison, the necessary intake for a child is about one gram daily. When calcium intake or absorption is inadequate, or if the blood and tissues are unable to hold it in adequate quantities, there is increased nervous irritability which is frequently manifested by tetany. We should mention at this point that parathormone must be present to keep calcium at a normal level.

Phosphorus is equally as important as calcium to the human skeleton. Most of this element is present in bone tissue, and in the cells. It acts in combination with calcium in the skeletal development of the human being. Phosphorus also acts in coenzyme formations, and in the absorption of carbohydrates from the intestine by means of phosphorylation, i.e., the combination of phosphorus with ingested foodstuffs.

Magnesium is stored in the skeleton and its replenishment occurs by way of the intestine, as does calcium and phosphorus replenishment. Whether magnesium exerts a strong effect on skeletal maturation remains unknown.

This brief résumé of the basic mineral components of skeletal maturation should demonstrate the body's requirements for growth. The other trace minerals may also play an important role, but little is still known about their specific action.

The ossification of the skeleton proceeds in an orderly pattern, standards for which are available in several excellent sources. The variability of this pattern among perfectly normal children is given an excellent review, in the Harvard Growth Study.[5] In this study, the variability is recognized and the recording is made in percentiles.

Johnston considers it normal up to the third year, for a child to have bowed legs, pronated feet, a tendency to inversion and a protuberant abdomen. From 3 to 6, overcorrection and genu valgum occur. By 6, the knees are usually straight and the feet parallel; lordosis diminishes to a greater extent and is no longer a prominent feature.

The patients presented in this study were all of the asthenic body type; lordosis was not a prominent feature. Pronation was present in all cases, ranging from mild to severe. General postural difficulties as short hamstring muscles and postural slouch

TABLE II

Sex	Patient	Chronological Age	Skeletal Age	Area of Involvement	Subjective Symptoms	Objective Symptoms
M.	T.F.	8	6	Midtarsal regions	Tires easily; anorexia	Pronation and postural slouch
M.	N.J.*	7	4	Midtarsal and wrists area	Toes in and clumsy gait	Pigeon toeing and pronation
M.	H.D.	6½	5	Midtarsal and wrists area	Tires easily; anorexia; awkward gait	Pronation
M.	L.A.	6	4	Midtarsal regions	Tires easily; pain in feet	Pronation
M.	M.H.	5½	4	Navicular, bilateral	Feet hurt; tires easily	Pronation
F.	P.A.	5½	3	Navicular, bilateral	Pain in legs at night	Pronation
F.	J.K.	5½	4	Navicular, bilateral	Not active; leg pains	Pronation
M.	T.G.	5	3	Midtarsal and wrists	Child not active; leg pain at h.s.	Pronation
F.	K.C.	4½	3	Navicular, bilateral	Dislikes walking; tires easily	Pronation
M.	A.H.	4½	3	First cuneiforms and naviculars	Pain in legs at h.s.	Pronation
M.	F.M.	4½	3	Navicular and first cuneiforms	Tires easily; anorexia	Pronation
M.	G.K.*	4½	3	Midtarsal and wrists	Poor diet; not active	Pronation

*Radiographs demonstrated

were present, but only to a mild degree. The most prominent features in all of the patients were inability to maintain physical activity and poor eating habits.

In treating the pediatric foot problem, we must consider nutrition to be a foremost factor. The modern diet of the present day as a rule is very adequate. However, children are extremely active and utilize great amounts of energy in their daily life. Failure on the part of the parents to enforce good eating habits can only lead to difficulties. If this is discovered by the practitioner, it should be carefully surveyed. One cannot treat the foot alone, but the patient as a whole.

In this study, the author has attributed retarded osseous development, in part, to the individual's inability to replenish the mineral content of the tarsal, and in some instances, the carpal regions. A number of these patients complained of a tired feeling

Fig. 1—Left, Normal development, male, age 5½ yrs. Right, Retarded development, male, age 7.

at mid-day. All patients were considered in good health by the family physician. Stress in these areas also plays a great role; the blood supply to osseous structures is impeded, thereby affecting normal development.

If a part does not perform to its fullest extent, fatigue will set in more rapidly than usual. The end product is inadequacy in both physical activity and metabolism.

In the pronated or weakfoot with retarded osseous development, stress plays a great role in decreasing the foot's ability to carry out its tasks. This is where mechanical therapy serves as a definite adjunct to increasing foot function. As structure follows function, the end result will be a decided improvement in both the osseous development and the orthopedic condition.

Therapy and Results

In all 12 children of this study summarized in Table II, the most prominent feature was the retarded osseous development in the midtarsus. (Fig. 1, right.)

The author utilized both leather and metal appliances to increase foot function. Shoe padding and wedging are also effective, but to a lesser degree. As an added supplement to the daily diet, and as an inducement to appetite stimulation, a vitamin-mineral preparation was prescribed. On the following visits, a check was made as to the general effect of the added supplement. In all cases, the appetite was enhanced within 6 to 8 weeks.

At the end of a year, the child's feet were radiographed and a comparison was made with the original radiographs. Definite changes in bone growth were evident in all cases. The mechanical problem had also responded very well. The greatest improvement was noted in patient N.J. (Fig. 2). The general foot condition had greatly improved and the osseous development had advanced rapidly. Patient G.K. also made very good progress in both bone development and foot function. (Fig. 3.) Seven of the twelve cases are still under therapy.

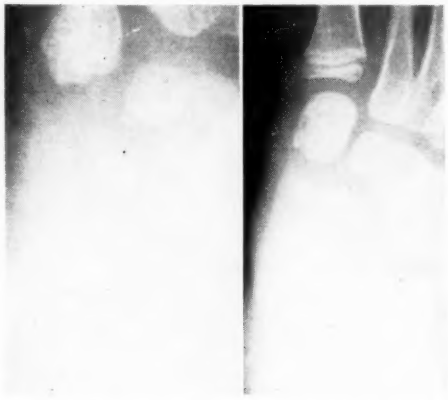


Fig. 2—Patient N.J. Left, at start of study, age 6½ yrs. Right, at age 7½ yrs.

Summary

A case study of 12 patients has been presented. The relationship of retarded osseous development and weakfoot has been explored, and the importance of a vitamin-mineral supplement in addition to mechanical therapy in such cases has been illustrated.

Although this is only a small study, it does demonstrate the definite need for a carfeul perusal of the podopediatric patient as a whole. Mechanical therapy is of the utmost importance in maintaining foot posture. Adequate nutrition should also be

Fig. 3—Patient G.K. Left, at age 4½. Right, at age 5½.

included in our armamentarium of therapy.

Retardation of osseous development points out the need to include adequate nutrition as a therapeutic measure.

242 Lexington Ave.

References

1. Brachman, P. R.: *Mechanical Foot Therapy*, Leicht Press, Winona, Minn., 1946.
2. Dickson, F. D.: *Posture, Its Relation to Health*, Lippincott, 1921.
3. Johnston, J. A.: *Factors Influencing Retention of Nitrogen and Calcium in Period of Growth*, Am. J. Dis. Child., 59:287-309.
4. Stearns, Genevieve: *The Mineral Metabolism of Normal Infants*, Physiol. Rev., 19:415, 1939.
5. Stuart, Harold C.; Hill, Penelope and Shaw, Constance: *The Growth of Bone Muscle and Overlying Tissues as Revealed by Studies of Roentgenograms of the Leg Area*, Published by Soc. for Research in Child Development, National Research Council, Washington, D. C., 1940.
6. Macy, I. G.: *Nutrition and Chemical Growth in Childhood, 1, Evaluation*, Thomas Publishers, Springfield, Ill., 1942 (p. 154).
7. Shelton, E. K.: *Roentgenological Studies in Normal Osseous Development*, J.A.M.A., 96:759, 1931.
8. Meredith, H. U.: *The Rhythm of Physical Growth*, Univ. of Iowa Studies, XI, 3, Feb., 1935.
9. Todd, T. Wingate: *Atlas of Skeletal Maturation*, C. V. Mosby Co., St. Louis, Mo., 1937.
10. Sante, L. R.: *Principles of Roentgen Interpretation*, 8th Edition, Edwards Brothers, Inc., Ann Arbor, Mich., 1949.
11. Tax, Herman R.: *Podopediatrics, The Care of Children's Feet.*
12. Manual of Orthopaedic Surgery, American Orthopaedic Assoc., 1952.
13. Barness, L. A.: *Manual of Pediatric Physical Diagnosis*, Year Book Publishers, Inc., Chicago, Ill., 1957.
14. Gray, Henry: *Anatomy of the Human Body*, 25th Edition, Lea and Febiger, Philadelphia, 1949.
15. Dearborn, W. F., and Rothney, J. W.: *Predicting a Child's Development*, Cambridge, Mass., Sci-Art, Publishers, 1941.

The Fabrication of Contact Appliances For Use in Conventional Footwear*

Samuel Rosoff, Pod.D.
Bronx, N. Y.

Introduction

THE objectives of this paper, which has spanned a period of some 10 years, are twofold:

1. To achieve the best rehabilitation of which the human foot is capable by placing it in the best environment is scientifically and practically possible.

2. To achieve this result using, insofar as is possible, conventional footwear, readily available in the average shoe store, of a type esthetically acceptable to the patient and at the same time allowing the foot specialist the widest possible latitude in patient control.

During a 10-year span, the writer has introduced three basic modalities, each in its own way designed to meet the needs of everyday practice problems. All of these aforementioned modalities are fabricated in accordance with a common basic concept: they are moulded dynamically in direct contact with the human foot, avoiding the inadequacies and physiological failures of appliances made over the widely

*Condensation of the 1960 Drew Award Paper.

ased and commonly accepted plaster cast. Hence the appelation "Contact" which we shall use in our descriptive terminology.

A preliminary report of our original findings in this phase of podotherapeutic management was published in 1953. This reported a description of the fabrication of two basic moulded appliances for use in conventional footwear, ranging from the conservative walking type of shoe through the various types of semi-dress shoes, on to the high fashion types of dress shoe.

A subsequent report, published in 1955, entitled "The Contact Sandal," described the third of these modalities.

This report shall describe the most recent in the series of contact appliances, a conventional contact sandal, together with a revised and improved method of fabricating the original two prosthetics.

It is obvious that the foot specialist should have in his armamentarium a diversity of devices, simple of fabrication, anatomically and physiologically correct and corrective, and further, that these devices should be readily adapted to acceptable, conventional footwear.

The Conventional Contact Sandal

The conventional contact sandal may be defined as a casual type of sandal which has been converted, by the addition of a moulded platform, into a rehabilitative, therapeutic, orthopedic modality, designed for the specific needs of the patient, under the supervision of the foot specialist.

The conventional contact sandal differs from the original contact sandal by overcoming two basic shortcomings of the original modality, namely a somewhat unconventional appearance and perhaps more important, the complexities of fabrication of the appliance.

The ultimate objectives of the contact sandal are: to place the foot in an environment simulating as closely as possible that of barefoot walking, and to create a type of footgear, protective and rehabilitative in nature, whose function is to induce toe flexion in varying and controlled degrees.

Indications

The indications for sandal therapy are many and varied. In the practice of podopediatrics, sandal therapy may be a valuable adjunct in the control of the imbalanced foot, stimulating proper muscular control in the child, allowing for proper growth in a free, unfettered environment. Muscular shortenings, or other shortenings in the foot and leg may be readily compensated for in the fabrication of the sandal.

The great range of toe problems which face us in daily practice again finds some solution in sandal therapy. In conjunction with orthodox office procedure, the inverted nail, the hammer toe, the overlapping or underlapping toe, the problem of pain and pressure relief in hallux conditions, all lend themselves to sandal therapy. Postoperative recovery is hastened and prognosis is better in the non-restrictive and protective environment of the sandal.

The problems or hyperdrosis, bromidrosis and many other dermatological conditions, induced or enhanced by the heat and friction engendered in the closed shoe, all lend themselves to the combination of intelligent management coupled with the healthy environment of the foot in the sandal.

The problems of podogeriatrics, which we face in greater numbers as the age level of our populace increases, also lend themselves to sandal therapy. The arteriosclerotic, the whole range of problems of vascular embarrassment, cannot but benefit in an area free from the pressure and irritation inherent in the closed shoe. Athritic changes, so commonly seen in this patient category, are frequently of such nature that the very fitting of a shoe presents a well-nigh insurmountable problem. It may be well to mention at this point that should gross tissue changes be of such nature that a conventional sandal cannot be properly fitted, the original contact sandal is then indicated. It may be here noted also that where indicated, the podotherapeutic values of the sandal may be

closely controlled. The ratio between the "static" and the "dynamic" potential of the sandal may be varied by modifications in the impression-taking techniques. Where plantar flexion cannot or should not be induced the moulding may be done with little or no pressure on the platform. The resultant sandal will have minimal contouring, and may be described as a "static" appliance.

Foot structures which have been hampered in normal growth and deformed or debilitated over a period of years lend themselves to rehabilitation slowly. The sandal, depending on the individual case, should be worn for short periods of time, to a point of tolerance, gradually increasing the wearing time each day. To do otherwise is to invite severe reactive processes.

Contraindications

1—Exposure to injury

Certain occupations wherein the wearer may be subject to mechanical or chemical damage to the foot as a result of wearing the sandal would render it useful only on a part-time basis, during leisure hours.

2—Exposure to cold

The use of the sandal may be limited by climatic considerations in areas where severe cold may prevail. Again it may be used on a part-time basis during these seasons.

3—Acute inflammatory reactions

The use of the sandal is to be avoided during the active phase of any acute infective process, or any inflammatory process during which gross tissue changes may be anticipated. After proper control has been instituted, when these conditions have reached a subacute or chronic stage, or have been reversed successfully, sandal therapy may then be instituted.

4—Idiopathic ankle edemas

The patient who is prone to idiopathic ankle edema, particularly during warm weather, or from the pressures, however

Fig. 1

mild, of ankle straps encircling the foot, is not a fit candidate for sandal therapy. A careful history will elicit this information from the patient before the sandal is chosen as the modality to be used.

Selection of the Sandal

The patient is given the widest latitude in selecting a sandal. Color and style are of little consequence, providing the following two factors are rigidly observed:

1. The sandal must have a front strap or straps (Fig. 1), that may be adjusted. This is necessary, so that when the moulded platform is inserted (as shall be described later) the strap may be opened in such fashion that proper positioning of the foot is feasible. Hence, the sandal should be fitted so that there is sufficient length in reserve in the front strap to permit of its being opened a notch or two. The salesman should be instructed to fit the sandal as he ordinarily would, with the patient's regular size, keeping this one factor in mind.

2. The height of the wedge of the sandal should be in keeping with that which the patient is most accustomed to, unless there are some special indications for variance. In this instance, the height may be increased or decreased by so instructing the salesman.

Techniques of Construction

Materials: Felt, approximately ¼" thickness (65% wool, 35% cotton); Specialist®[1] surgical stockinette, 3" width; Latex (3-E-6-S natural) *; Wood Flour (Lignum —M-I) †; Plaster of paris (in shaker top can); Lubricating cream (for operators' hands and patients' feet) ‡; China marking pencil (red); Enameled Pan (approx. 11" x 14"); Spatula; All-purpose Cement; Leather; Motorized grinding wheel; Scissors.

Preparation of the Moulded Platform

The sandal which the patient has purchased and brought to the doctor for approval is now ready for conversion to a moulded sandal.

1. Place the sandal on the felt, and with the China marking pencil make an outline of the sole on the felt.

2. A series of "X" marks, or "left" and "right" is then drawn on the superior surface of the felt, to distinguish the "left" and "right" platforms through later stages of the fabrication process. Cut the platforms out, following the red outline marks accurately. Allow a slight excess of felt toward the front.

3. Prepare a solution of equal parts of 3-E-6-S latex and water. (The type of latex used is a synthetic latex, of fairly heavy viscosity, natural color.) When used undiluted with water, we shall refer to it as "thick" latex. When diluted with equal parts of water it shall be referred to as "thin" latex. The thin latex is poured into the enameled pan and the previously cut "platform" is immersed in it. Saturate the felt thoroughly and squeeze the excess latex from it. The hands should be lubricated with creme prior to using latex, in order to facilitate removal of the dried latex later. An apron is suggested to protect the clothing of the operator. Place the platform, "X" side up, on a working surface (a Formica-covered board is desirable) and smooth out to original contours.

4. Spatulate a layer of thick latex on the "X" side of the platform.

5. Prepare a mixture of "Rubber Butter" as follows: Mix equal parts of wood flour and thick latex in a jar until a fairly stiff consistency is achieved. The amount needed will vary with the indications of the case under treatment. A total of approximately 6 oz. should suffice for the average pair of sandals. Coat the topside of the platform with a layer of rubber butter approx. ⅛" thick (not shown). Additional butter may be added in the areas of the sulcus, the arch, the calcaneal area, or wherever the indications of the case call for spot balance or correction.

6. Cut a length of surgical stockinette several inches longer than the mould being fabricated and slit it along one side, opening it to a six-inch width. Dust the surface of the material with an even coating of plaster of paris.

7. Place the platform topside (rubber butter side) down on the stockinette, centering it on the material. Make an envelope of the cloth around the entire felt mass. This is done by gathering the ends of the cloth and forming butt-pleats, scissoring away the excess.

Care should be exercised in gathering the cloth together, so that the original dimensions of the felt platform are not distorted. The felt should be coated with thick latex and dusted with plaster of paris, on the side opposite the one coated with butter, prior to starting the butting process. The plaster of paris, which acts as an accelerator for the latex in setting, helps the cloth to adhere to the felt. The finished envelope should consist of the felt, latex, rubber butter and cloth, all welded together with neatly butted seams, following the original contours of the felt platform. The entire platform is then placed, butted side down, smooth side up, and is ready to receive the impression

®[1] Johnson & Johnson, New Brunswick, N. J.

* General Latex & Chemical Company, Cambridge, Mass.

† Lignum Chemical Works, Long Island City, N. Y.

‡ Author prefers Hydrisinol Creme, Pedinol Products, New York, N. Y.

of the patient's foot. At this point it may be well to check the dimensions of the finished platform with that of the sole of the sandal to be sure that no wide variances have occurred. If this has happened, it is a simple matter to reshape the platform to conform to the sandal before proceeding with the taking of the impression.

Impression Technique

The patient is seated with the foot and leg in the classic right angle position. The plantar surface of the foot is lubricated, and placed lightly on the platform. The heel should be well back on the mould, and the foot centered (Fig. 2). The patient is then instructed to put full weight to bear on the mould while remaining seated. At this point the operator presses firmly on the toes so that a good impression of the forefoot is registered. Some oozing of excess latex may emanate from the mould and may be wiped away. The patient is then instructed to resume normal leg weight, with the foot in a relaxed, rest position. At this point, the felt is moulded with a firm spatula (a blunt kitchen knife serves admirably) in such fashion that an abutment is created around the circumference of the foot. The moulding should extend from the head of the first met around the foot to the head of the fifth met, with particular emphasis on the contouring of the arch.

The areas anterior to the first and fifth met heads are *not* buttressed, the pressure of the operator's hands during the impression stage being sufficient. We have now, in effect, taken a semi-weight-bearing impression, and restored the mould to a rest position. The foot is then removed and the mould set aside to "cure" for 2 or 3 days. It should be noted that there remains enough "dynamics" in the mould so that when the patient begins to wear the sandal —usually in from 10 days to two weeks—a true "dynamic" impression is gradually created by the patient over a period of time.

Residual latex and lubricating creme may be removed from the patient's foot with a damp towel.

Fig. 2

An ideal casting board consists of a piece of heavy plywood to which is bonded a covering of Formica. An over-all size of approximately 16″ square is ideal, and is readily obtained at the hardware store. The entire moulding procedure may be done at the office chair by raising it to a comfortable working height, foot rest swung aside, formica board in position. When the moulding is completed, the board is removed and the moulds set aside, undisturbed, to dry.

Finishing

After the mould has dried (48 hours should suffice), the edges are squared and shaped to conform with the sandal into which it is to be placed. This is done on an ordinary sanding wheel. Should it be too long or too wide, the excess may be readily removed. Should additional bulk be needed, a piece of scrap felt is dipped in latex and adhered to the mould. After it is dry, it may be readily ground and shaped to the desired proportions.

The mould is carefully covered with leather matching the sandal, kidskin is preferred. The sock lining the sandal is frequently plastic-coated and should be sanded before cementing in the mould. The conventional contact sandal is then complete (Fig. 3).

Instructions to the patient should be detailed.

The sandal should be worn for short periods of time, gradually increasing according to the patient's tolerance, although untoward reactions with the sandal are generally minimal. Should additional heel height be indicated, a wedge of the desired thickness may be adhered. It should be emphasized that the moulded platform is

Fig. 3

"permanent" in nature, and should the sandal be ready for discard, the mould may be removed, covered in a leather to match the new sandal the patient has selected and adhered into the new sandal quite readily, following the instructions outlined above. From time to time, a new sock lining may be indicated, and this, too, may be readily replaced.

Spot correction of the mould may be achieved, when necessary, by removing the mould from the sandal, and either stripping back the sock lining or working from underneath the mould, depending on the type of modification to be attempted. It has been the experience of the writer that corrections should not be attempted until sufficient time has elapsed to allow normal healing processes to develop. Fortunately, because of the nature of the device, and because the foot has been placed in an optimum environment, corrections are minimal and conservative in nature in most cases.

It should be pointed out that a moulded appliance has been described which is indicated in the "average" type of case seen in the office. Variations in the fabrication of the platform are, in a sense, limited only by the indications of the case and the ingenuity of the operator. For the unilateral shortenings of limb or foot, for variations in distribution of adipose tissues, for plantar or dorsiflexed toes and the numerous problems which daily confront us, we may vary the thickness of the felt, the amounts and the consistency of, and in fact, the placing of, the "rubber butter."

With a little ingenuity on the part of the operator, some special care and slight variation of materials, the "platform" described (contact mould) can be fabricated for other conventional shoes. Also a forefoot platform can be designed for use with high-style dress shoes.

1573 Westchester Ave.

"I am the State," boasted the proud and arrogant Louis the XIV of France, who also called himself The Great.

But when the august King died, the funeral oration, preached in the unlighted cathedral by Bishop Jean Baptiste Massilon, consisted only of these four words:

"Only God is great."

The Need for Specialized Shoe Lasts to Accommodate The Commonly Occurring Foot Pathologies and Gross Structural Deviations*

D. D. Ressler, D.S.C.†
Cleveland, Ohio

THE longitudinal axis of the structurally sound foot, in the position of stance, passes from the weight-bearing surface of the calcaneus and continues forward to bisect the space between the heads of metatarsals two and three. It terminates between the second and third toes. This axis, due to the eccentric (lateral) relationship of the calcaneus to the forefoot, is parallel with, or inclines slightly toward the great toe. It inclines more strongly toward the great toe in the presence of hallux valgus. The structurally sound foot is balanced (neither pronated nor supinated) over this axis. The long axis of the shoe, if conflict with the foot is to be avoided, must follow the same pattern as the aforementioned long axis of the foot.

Since all of the structures of the heel must be accommodated by the shoe, we felt that there should be accurate identification of the weight-bearing surface of the calcaneus in relation to the total inferior heel surface. In the position of stance, the weight-bearing surface of the calcaneus is the posterior pillar of balance, and its exact location determines the inclination of the long axis of the foot.

Investigation was carried out in the dissection laboratory of the college, where leg and foot specimens were available. The contour of the inferior surface of the calcaneus presents a medial and lateral tubercle. The calcaneus inclines inferomedially. The medial tubercle acts as a check against the forces of pronation. The area lateral to the medial tubercle is quite flat. This flat surface is bounded laterally by a very shallow channel. Beyond this channel and somewhat superiorly located, is the lateral inferior tubercle, which acts as a check against excessive supination. It is the aforementioned flat surface, including the inferior surface of the medial tubercle, on which the heel is balanced in the position of stance.

From specimens dissected in the laboratory, the conclusion was reached that the weight-bearing surface of the calcaneus is in the center of the total inferior surface of the heel. The arrangement of the soft tissue accounts for this central location. Under the sustentaculum, there is a heavy depot of soft tissue and fat cells. On the lateral side of the calcaneus, the bone is covered with little more than skin and fascia.

Present terminology which describes the relationship of the forepart of the shoe to the rearpart consists of the terms: (1) Straight, (2) Inflare, (3) Outflare. Such simplification is not supported by investigation. The most commonly seen foot shape variations and the most frequently occurring pathological shape deviations present complexities which cannot be disposed of so easily.

Manufacturers, covering most comprehensive lines of basic comfort footwear, all claim that their lasts are correct in regard to shape and design. Since they all make shoes that are characteristically different from one another, it must follow that concepts in last design do not have a scientific basis, but are rather artistic endeavors. What is needed is a fresh perspective; a more scientific approach is necessary for the purpose of standardization of last design.

In this project, we have tabulated the X-ray studies of the feet of 84 patients at the Ohio College of Chiropody Foot Clinics. Our aim was to record statistical information in regard to shape deviations which occur commonly in the presence of gross anomaly or pathology, those struc-

*This study was conducted under the 1959-60 Irving Drew Grant-in-Aid for Shoe Research.

†Assistant Professor of Chiropody, Department of Shoe Therapy, Ohio College of Chiropody.

tural deviations which affect the shape relationship of the rearfoot to the forefoot, or the contour of either. Where such changes in relationship or shape are present, obviously one of two courses must be followed if the individual is to be comfortably ambulatory.

1. The condition must be corrected or a reversal must be induced by some means of therapy.

2. In the event that the condition is irreversible or intractable, it must be accommodated.

The former course of action often presents serious difficulties. The latter may be equally difficult, if not next to impossible, with stock shoes.

As a basis for comparison with our findings, we attempted to investigate and evaluate the shapes of the insoles of the better grades of women's comfort type shoes. (Access to the lasts would have added much to the investigation.) In evaluating the insole patterns effectively, it was necessary to consider the overhang of the last in the heel and cuboid area, as well as the tarsal area and the shafts and heads of metatarsals one and five. Since this phase of our effort was somewhat inconclusive, we will pass over it rather quickly. Certain observations, however, are worthy of mention. It would appear that a frequent error in the concept of last designing is to rely on "last overhang" instead of "bottom." It should be fairly obvious that the bottom of the shoe is a sounder foundation for the foot to seat itself than is the counter or upper. In most instances, the evaluation of the insole revealed that its long axis was aligned quite favorably with that of the structurally sound foot. There was considerable difference in the treading area at the ball when comparison was made between the basic lasts by a given manufacturer (1″ heels) and the lasts with higher heels (14/8 to 15/8″). At the ball, the difference in treading area was in favor of the 1″ heel last to the extent of 8 to 10 percent. This was, of course, to be expected. There was also additional bottom area for the heel, cuboid, and base and shaft of the metatarsal five.

A conclusion that can be drawn from the above rather sketchy observations is that the fitting of the structurally secure foot (without serious shape deviation) does not present great difficulty to fitting in the average good conventional shoe. For obvious reasons, we did not attempt to evaluate the snug, stylish type of shoe. We shall assume that it is taken for granted that shoes made on short vamp and/or pointed lasts are usually traumatic.

We have suggested that the last and shoe shape terms, straight, inflare and outflare, describe foot pathology or shape anomaly. They are of such a vague nature as to practically defy correlation. There are a number of commonly seen foot pathologies and anomalies which affect the shape of the foot, and the relationship of the rearfoot to the forefoot. If these syndromes were given careful consideration by last designers and shoe manufacturers in cooperation with members of the medical arts, it would probably be possible to arrive at some conclusions as to how specialized lasts could be best correlated to accommodate feet which present pathological or commonly occurring gross shape deviations. It is quite obvious that correct answers to the many problems that exist in the development of good lasts for problem feet can only be found through the medium of extensive and exhaustive research. It is equally true that the statistics which we shall present from our small series of 84 cases are also inconclusive.

Our first step was to determine what were the most prevalent pathologies and anomalies of the feet, so common as to be very widespread. Some of these conditions are reversible, some are intractable. Some are amenable to surgery. From a practical standpoint, we are aware that many patients are unwilling to undergo what may be a major surgical procedure to have a foot condition permanently corrected. The nature of some major surgical procedures on the feet (triple arthrodesis, fasciotomy, etc.), are such that positive results are not assured. They might be considered too

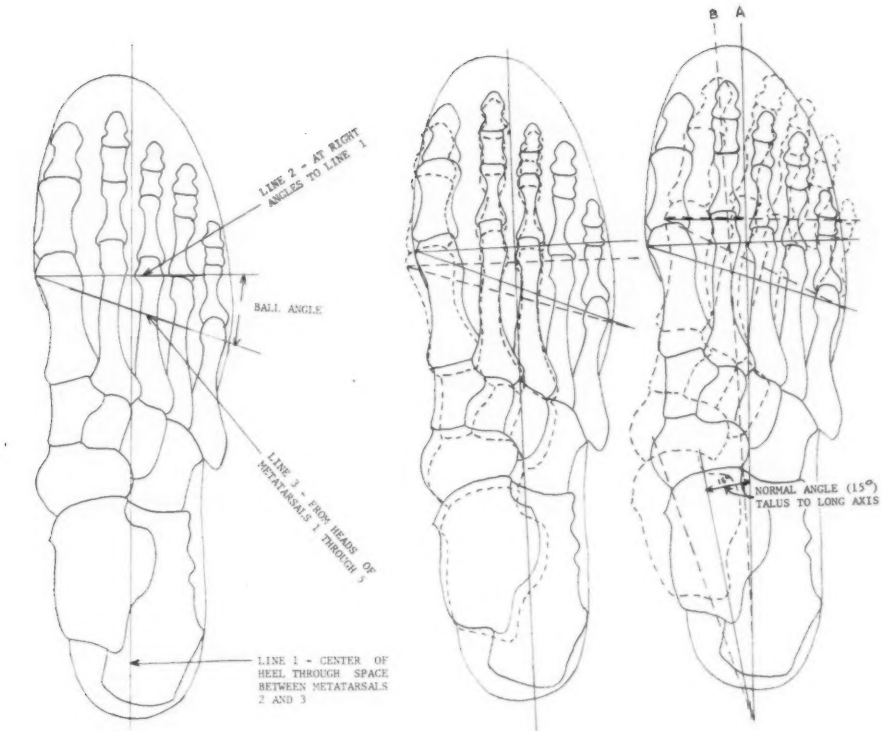

LINE 2 - AT RIGHT ANGLES TO LINE 1
BALL ANGLE
LINE 3 - FROM HEADS OF METATARSALS 1 THROUGH 5
LINE 1 - CENTER OF HEEL THROUGH SPACE BETWEEN METATARSALS 2 AND 3
B
A
NORMAL ANGLE (15°) TALUS TO LONG AXIS

Fig. 1 Fig. 2 Fig. 3

Fig. 1—Illustration of method used to determine ball angle. Fig. 2—Supinated or Contracted Foot. Broken lines illustrate presence of Metatarsus Primus Varus, reduced length of medial segment of foot and reduced ball angle. Fig. 3—The Pronated Foot. Broken lines illustrate elongation of medial segment of foot, increased angle of talus, and medial shift of long axis. Also the increased ball angle and lateral relationships of forefoot to rearfoot.

radical to be accepted as the modality of choice.

What, then, is the next best thing? Accommodation. If you can't change it, accommodate it. It was this kind of reasoning that created the current mode for custom moulded footwear.

There are a number of common foot conditions which have a definite influence on the ability of the shoe to house the foot comfortably. Some are anomalies. Some are pathological. Others are due to heredity or environment. In any case, the design of the special shoe must be based on pertinent information and statistics. There are many factors and some are:

1. What is the prevalence of the condition? Obviously, it must occur commonly and frequently or it would not be economically sound to consider accommodation on a ready-made basis.

2. Measurements of the special lasts must be designed so as to best accommodate the majority of feet in each category.

3. Does the condition occur independently or in combination with related conditions? If so, to what extent, and how frequently?

4. What other conditions of the feet cause them to assume a similar contour?

Since this project is concerned primarily with last design, emphasis is placed on morphology rather than physiology. Only structure can be embodied in a shoe last. Physiology (function, bio-mechanics, dynamics) must be incorporated in the construction of the shoe. This is a separate study, and we shall not concern ourselves with this.

Our study covers 84 cases. The subjects were selected at random. Morphological data were recorded in each instance for the purpose of determining its ratio of incidence and severity. The categories selected for investigation were those which we considered to be the most difficult to accommodate in the average, good conventional shoe. In describing the degree of involvement, we have used the terms: (a) mild, (b) advanced, (c) severe. We felt that more detailed description would not enhance the study.

Metatarsus Primus Varus

This condition is characterized by a widening of the joint space between the heads and shafts of metatarsals one and two. It is often associated with a laxness of the ligaments of the first metatarsal segment which contributes to a pronatory position of the foot. However, it frequently occurs without other complications excepting hallux valgus, with which it is almost invariably associated to a greater or lesser extent.

The salient change that takes place in the shape of the foot in the presence of metatarsus primus varus is a broadening of the forefoot. This necessitates a shoe with a treading area to accommodate the increased medial ball displacement. When metatarsus primus varus occurs in association with pronation, the need is for more treading area to accommodate the increased lateral ball displacement. This is because the long axis of the foot shifts medially. In the event that all of the metatarsal spaces are widened, the foot is usually classified as splayed. Of our series of cases, only two could be classified as splayed feet. For this type of foot, the total treading area must be greatly increased.

Since metatarsus primus varus is almost always associated with hallux valgus, the shoe that adequately accommodates one will be a good type for the other. The exception to this is severe hallux valgus, where a large amount of bone overgrowth occurs on the medial side of the head of the first metatarsal. In these cases, both additional medial treading area and last bulge on the medial side of the ball are indicated. (Fig. 1.)

Table I shows the frequency with which the varying severity of metatarsus primus varus is related to absence or severity of pronation.

TABLE I

	Metatarsus Primus Varus			
Pronation	Absent	Mild	Advanced	Severe
Absent (28)	5	13	8	2
Mild (29)		16	11	2
Advanced (25)	3	6	13	3
Severe (2)			2	

Although the evidence from such a small number of cases is inconclusive, it would appear that pronation and metatarsus primus varus are not strongly related. Of the 28 cases where pronation was absent, only 5 did not exhibit metatarsus primus varus. Of the remaining 23, 13 were mild, 8 advanced and 2 severe.

It should also be noticed that of the 25 cases of advanced pronation, there were 3 cases in which metatarsus primus varus was absent. This seems to indicate that pronation and metatarsus primus varus are not necessarily related. Generally, however, where pronation was mildly present, the incidence of metatarsus primus varus increased, and when pronation was advanced or severe, metatarsus primus varus increased proportionately in prevalence and intensity.

It is extremely significant that metatarsus primus varus was present to some degree in 76 of the 84 subjects we examined. Cases were classified as "mild metatarsus primus varus" only if there was definite widening of the space between metatarsals one and two. In every instance, the lateral sesamoid was at least partially encroaching on the first metatarsal space as seen on a dorsoplantar X-ray.

Metatarsal Length Patterns

The importance of the incidence of the various metatarsal length patterns is undeniable since this factor directly influences the ball angle. While the ball angle may

TABLE II

Ball Angle Related to Metatarsal Length Pattern

Metatarsal Length Patterns	Ball Angle in Degrees																		
	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	28
2-1-3-4-5-(54)					1	1	2	3	5	5	2	13	5	5	4	4	2	2	
1-2-3-4-5-(6)								1						1	2	1			1
2-3-1-4-5-(22)		1		2		2	1	5	4	6		1							
2-3-4-1-5-(2)	1		1																

vary greatly in any given metatarsal length pattern, it must be remembered that there may be great variation in the length of the metatarsals in any given pattern.

The ball angle was determined by the following method: (See Fig. 1).

1. A line was drawn to represent the longitudinal axis of the foot (from the center of the heel through the forefoot between metatarsals one and two).

2. A second line was drawn from the medial edge of the head of metatarsal one to bisect the forefoot at right angles to its long axis.

3. A third line beginning at the same point as line two was continued through the head of metatarsal five.

The angle between lines "2" and "3" was measured to determine the ball angle. The data which resulted shows the relationship between metatarsal length pattern and ball angle.

Table II records the incidence of the four metatarsal length patterns observed and the degrees of ball angle for each pattern.

More than one half of the metatarsal length patterns (54) are 2-1-3-4-5. The most frequently occurring ball angle is 20° (13 cases). The second most frequent metatarsal length pattern encountered was 2-3-1-4-5 (22 cases). Here we notice that the ball angle decreases, the most prevalent being 16° to 18°. There were a few patterns of 1-2-3-4-5- (6) which presented a generally increased ball angle, and only two cases of pattern 2-3-4-1-5, which presented a greatly reduced ball angle.

While much research along these lines is indicated in order that stock lasts be properly correlated to the feet that they must match, the results of our small effort should fairly well illustrate the need for much more statistical information.

Morton's Syndrome

Seventeen cases (20% of the total) were diagnosed as having Morton's syndrome (short first metatarsal and hypertrophied second). Shapewise, they are characterized by a reduction in ball angle and, because of the shortness of the medial pillar of the foot, a tendency toward pronation.

Table III shows the ball angle for these cases.

TABLE III

Ball Angle in Degrees for 17 Cases of Morton's Syndrome

Metatarsal Length Patterns	Ball Angle									
	9	10	11	12	13	14	15	16	17	18
2-1-1-4-5		1		2		2		3	2	3
2-3-4-1-5	1		1							
2-1-3-4-5								1		1

The most frequent metatarsal length pattern in these cases was 2-3-1-4-5 (13 subjects). Of the remaining four, two (9° and 11°) presented a 2-3-4-1-5 pattern. The other two (16° and 18°) were 2-1-3-4-5 pattern.

This type of foot requires a shoe with a reduced ball angle. There seemed to be no definite relationship to metatarsus primus varus. It was found to exist about as often as not among Morton syndrome cases.

Since Morton's syndrome is usually associated with pronation, it follows that the shoe must also accommodate the pronatory

position of the foot, which we shall describe separately. In view of the fact that this condition occurred in our series as frequently as one case in five, it is certainly worthy of consideration as a condition that requires special accommodation.

The Supinated or Contracted Foot

This type is characterized by contraction of the medial side of the foot. The medial arch is high, the plantar fascia contracted, the head of metatarsal one is prominent. Metatarsus primus varus is usually present. The calf muscles are often shortened and when this is the case, the rear foot assumes a pronatory position as the heel contacts the sagittal plane. The deviation in shape is characterized, essentially, by the increased height of the medial arch, which causes several salient changes to occur in the gross contour of the foot.

1. The medial side of the foot is materially shortened.
2. The ball angle is reduced.
3. The lateral arch is now proportionately longer than the medial and requires more shoe area for accommodation.

While this type of foot sometimes presents the general appearance of Morton's syndrome, it differs in the respect that metatarsal one bears more than its proportionate share of weight and metatarsal two is not hypertrophied.

When fitted accurately from heel to ball in a conventional shoe, the lateral side of the shoe is invariably too short to accommodate the length of the lateral segment of the foot and the lesser toes. (Fig. 2.) Our survey revealed only six cases, (7.14%). The metatarsal length pattern was usually 2-1-3-4-5, with the metatarsal shorter than usual.

We have stated that there is sometimes similarity in shape between the supinated foot and the foot presenting Morton's syndrome. However, the Morton's foot usually pronates, but the supinated foot pronates only in the presence of shortened calf muscles. This pronation is reduced as the heel is elevated. The Morton's syndrome foot usually pronates under any circumstances. The chief similarity is that both have reduced ball angles.

Pronation

Pronation is a change in relationship between the talus and the calcaneus. The inferior surface of the talus departs from its proper alignment with the calcaneus as it rotates inward, forward and downward. The ligaments of the medial and medio-inferior aspect of the tarsus first become strained. As the strain continues, laxity develops and the medial arch of the foot becomes progressively lower as the neck and head of the talus lose proper contact with the calcaneus. The tarsus seems to bulge medially and the entire foot rolls inward as the anterior end of the medial pillar of the foot contacts the sagittal plane. This causes the longitudinal axis of the foot to shift medially and results in a reduced medial ball displacement.

As the talus rotates medially, it carries with it the bones of the leg. When such a foot is viewed from the rear, it appears that the foot has shifted laterally in relation to the leg. Actually, the tibia and fibula have moved medially in relation to the foot.

There are several characteristic morphological changes which occur in the pronated foot. Most of these changes are adversely affected by the design of the so-called orthopedic or health shoe.

1. The tarus of the foot becomes broader as the talus and navicular protrude medially.
2. The forefoot abducts to a greater or lesser degree.
3. The forefoot spreads when metatarsus primus varus is present, requiring more treading area.
4. The medial arch of the foot is lowered and will not tolerate, comfortably, an arch foundation that is not accommodative.
5. The span of the medial arch is increased in proportion to that of the lateral arch.
6. The ball angle increases in proportion to the degree of pronation.

7. The combined presence of metatarsus primus varus and hallux valgus causes the lesser toes to abduct, requiring more lateral space in the shoe.

8. As the long axis of the foot shifts medially, the medial ball displacement is reduced, and the lateral ball displacement increases.

The modern orthopedic or health-type shoe is well reinforced. It has a long medial counter, frequently combined with extra padding (cookie), and a fairly high or high arch. This reinforcement stabilizes the medial side of the shoe. Theoretically, this would help to hold the foot in proper alignment. Actually, it guides the foot into the lateral side wall of the shoe.

In order to avoid conflict between the pronated foot and the shoe, there must be an ample foundation. The inside of the shoe, at the breast of the heel (the tarsal area) must be widened on the medial side to accommodate the bulge of the talus. The arch of the shoe must slope gently and gradually from heel to ball. Too high a shoe arch causes the foot to rock and slip in the heel. Stability of fit and advantages of good pattern control are lost.

In the presence of pronation the forefoot abducts much more strongly in a shoe with a reinforced medial arch and long counter than it does in types with no medial arch reinforcement. This may account, to some extent, for the gain in popularity of the soft, casual type of footwear which has been so well accepted in the past decade.

While it is possible that the forefoot may abduct considerably at the midtarsal joint, the extent to which this occurs is less than is generally suspected. Normally, the range of motion around a vertical plane in the midtarsal joint is almost two to one in favor of abduction. The stabilizing element of the lateral arch is the long plantar ligament (calcaneo-cuboid). Motion on this side of the foot is more or less limited to axial rotation. Due to its great strength, the long plantar ligament so securely locks the bones of the lateral arch as to act as a check against laxity on the lateral side of the midtarsal joint.

In advanced and severe pronation, abduction at the midtarsal joint does frequently occur. Generally, however, the abduction is largely false. The forefoot appears to abduct because of the action of the reinforced shoe in guiding the foot lateralward.

Since the long axis of the foot shifts medially in the presence of pronation, the medial ball displacement of the shoe must be decreased, and the lateral ball displacement increased proportionately. Otherwise, the entire medial portion of the shoe, anterior to the talus and navicular, will be redundant.

The width of the treading area must be increased to accommodate metatarsus primus varus and hallux valgus. In six of our cases, there was a marked increase in the space between metatarsals four and five. This is the forerunner of tailor bunion, just as metatarsus primus varus is the predisposing factor in hallux valgus.

In the presence of structural stability, with the most prevalent metatarsal length pattern (2-1-3-4-5), the most prevalent metatarsal length pattern (2-1-3-4-5), the most frequently seen ball angle approximates 20°. If such a foot develops faulty talo-calcaneal relationship (pronation), the ball angle may increase as much as 3° or 4° as the medial arch span elongates and becomes progressively lower. It becomes obvious that the shoe in which such a foot is to be properly fitted must have an increased ball angle so that both its medial and lateral arch span approximates that of the foot.

We have used the term "medial ball displacement." The term refers to the percentage of the total width of the ball of the foot occurring on the medial side of the long axis. Since pronation causes the long axis of the foot to shift medially, the medial ball displacement decreases in proportion to the degree of pronation.

In order to standardize our technique in recording this data, we used the axis of the structurally stable foot (center of heel to interspace between heads of metatarsals two and three). We then corrected our find-

TABLE IV

Percentage of Medial Ball Displacement in Pronation

Pronation	Percent of Total Ball											
	42	44	45	46	47	48	49	50	51	52	53	54	56
Absent (28)						2		11	1	4	4	5	1
Mild (29)			1		6	5	4	6	4	2	1		
Advanced (25)		1	6	1	5	6	3	2		1			
Severe (2)	1				1								

ings on the basis of the extent of the medial rotation of the talus. The normal relationship of the talus to the long axis of the foot is about 15°. In the presence of mild pronation, if the talus rotated medially 3°, its angle in relation to the long axis would be 18°. The long axis of the foot shifts medially as the weight thrust of the tibia shifts medially with the talus. As a result of this sequence, the medial ball displacement decreases in proportion to the medial rotation of the talus.

Table IV relates medial ball displacement to pronation.

Our findings would indicate that the structural sound foot usually has a medial ball displacement ranging from 50 to 54% of its total ball displacement.

Pronation, because of the medial shifting of the long axis of the foot, causes the medial ball displacement to decrease in proportion to the severity of the pronation. Metatarsus primus varus, or the increase in space between any of the metatarsals, would influence medial ball displacement.

Summary

1. The popular terminology (straight, inflare, outflare) does not accurately describe shape relationship of the shoe to the foot.

2. Extensive study and research of the commonly occurring foot pathologies and shape anomalies should produce data leading to the development of improved lasts for problem feet.

3. Cooperation between interested shoe manufacturers and medical investigators is strongly indicated in the pursuit of pertinent information.

4. Most advertising claims by manufacturers of so-called "corrective" type shoes do not stand up under investigation.

5. In the past, manufacturers of specialized footwear have stressed "corrective qualities" rather than accommodative design. In our view, this approach is erroneous. The influence exerted by a shoe on an adult foot has not been known to change its structure.

The syndromes which we have enumerated; metatarsus primus varus, Morton's foot, supination (contracted foot), pronation, all occur with sufficient frequency as to warrant careful investigation. All of these conditions produce changes in the morphology of the foot which create special fitting problems. They pose a challenge which can be met only through research. All of these conditions affect either the relationship of the forefoot to the rearfoot, or the shape of either. They also affect the ball angle of the foot, as well as the medial and lateral ball displacement.

Rm. 512 Euclid Arcade

"All sunshine makes the desert."

—*Arab proverb*

A Device for Measuring Foot Deviations*

H. H. DiPiero, D.S.C.
Youngstown, Ohio

Some years ago I heard an excellent address[1] on children's foot problems and the importance of recording changes during the progress of treatment. This resulted in my devising the present instrument within the next several months and with which I have worked since that time. Chirometer is the name given the instrument.

This instrument can be used to measure: (1) Deviation of the Achilles tendon, (2) Extent of bowing legs, (3) Extent of knock knees, (4) Elongation of the foot on standing, (5) Degrees of extension and flexation, (6) Depression of the navicular on standing, (7) Amount of pronation, (8) Splaying of the metatarsals, (9) Forefoot drop, (10) Tibial torsion.

The device is especially useful in the management of children's foot problems. The measurements provide a record of progress. Tax[2] suggests a platform at eye level (24 to 36 inches high and 36 x 36 inches) for children's foot examinations. Additionally, three chairs of different sizes will be very helpful. These are: (1) a regulation chair, (2) a child's "toy" chair, (3) the small seat that one finds in restaurants that is placed on a regular chair for a child.

The instrument is made of clear plastic. It consists of a rectangular portion and a triangular portion at right angles to each other. The triangle is slotted and various scales are clearly marked (see illustrations). These are: 1. On the rectangle, (a) foot length scale (bisecting it), (b) flexion and extension scales, (c) Navicular deviation scale, and 2. On the triangle, (a) a protractor for measuring Achilles deviation, (b) sides of triangles scaled to measure bowlegs and knock knees. A spirit level can be taped in the angle to assist in accuracy.

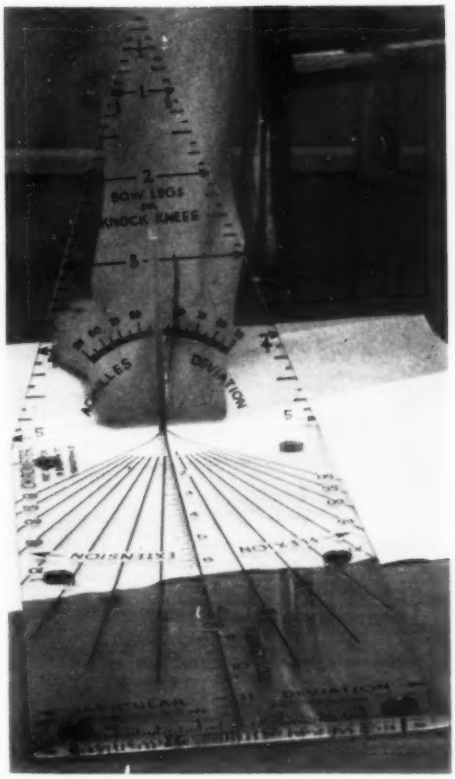


Fig. 1

The following paragraphs describe how it is used.

Achilles Deviation (Helbing's sign)

The patient kneels on a chair or table with the foot overhanging. The body is held upright without turning the head or shoulders. The Chirometer is then placed with the slot along the Achilles tendon and the point of the triangle pointing to the middle of the popliteal space. The midline of the rectangular part should bisect the midline of the plantar surface through the second and third toe web. A line is then drawn through the slot (using the refill of a ball point pen) keeping the pen perpendicular to the tendon. The patient stands and takes several marching steps in the same spot. With his back to the examiner,

*Condensed from paper awarded Bronze Medal in the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1960. Presented at the Annual Meeting of the A.P.A., held at the Drake Hotel, Chicago, Ill., August 1960.

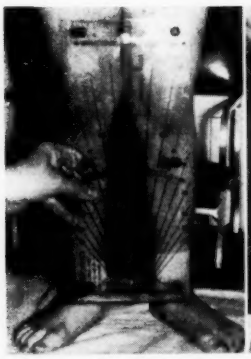


Fig. 2

Fig. 3

the patient is then instructed to stand still. The instrument is placed with the protractor against the heel and the deviation recorded (Fig. 1).

Knock Knees and Bowlegs

The patient stands for knock knee measurement. The tension at the knees should be such that a card can be slipped through with very slight pressure. The triangular portion of the Chirometer is placed at the medial malleoli (Fig. 2) and the width taken and recorded.

For bowlegs, the process is reversed. The medial malleoli are placed so that they are touching without pressure and the measurement taken between the knees (Fig. 3).

In a normal growing child these measurements should decrease every few months.

Length and Elongation of the Foot

The foot is placed on the Chirometer with heel held firmly against triangular portion and a reading is taken (Fig. 4), without weight bearing. The patient stands on the Chirometer and the reading taken again. The difference will be the amount of elongation of the foot. The normal elongation is $\frac{1}{8}$ inch.

Flexion and Extension

Draw a short horizontal line about $\frac{1}{2}$ inch long on the medial side to the first metatarsophalangeal joint, parallel to the plantar surface. Draw a similar line the same distance up on the foot on the medial border of the heel. The Chirometer is then placed or held at a right angle to the floor with the long axis up and the foot is placed into it with the lines drawn on the foot made to coincide with the long line bisecting the rectangular part. The foot is extended and flexed and the readings taken (Fig. 5). The average foot can be flexed about 10° and extended about 35°.

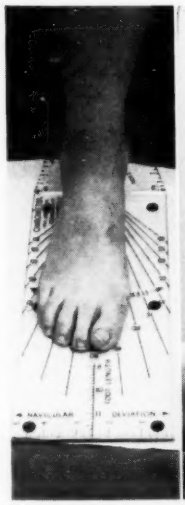


Fig. 4

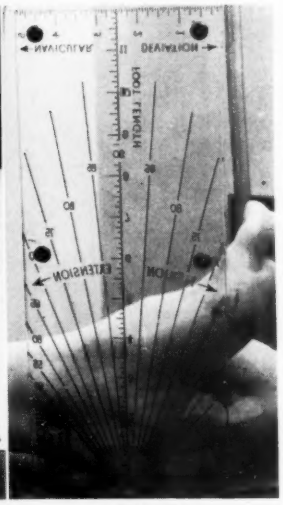


Fig. 5

Navicular Depression ("Drop" or "flattening" of the longitudinal arch)

The patient is seated and the foot placed on a flat surface with the foot at right angles to the leg. A mark is made at the navicular tuberosity. This height from the floor is measured and recorded (Fig. 6). The

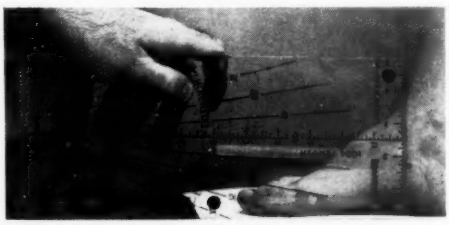


Fig. 6

patient is instructed to stand and lift legs up and down a few times. With the patient standing, the measurement is again taken from the floor to the spot on the navicular tuberosity. The difference between the two measurements recorded is the deviation. About $\frac{1}{8}$ inch deviation is the average for the normal foot.

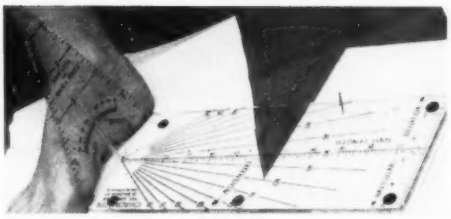


Fig. 7

Pronation

The term here is used to denote a medial roll of the arch, as differentiated from navicular deviation or flattening of the arch.

The patient is seated and the foot is placed on a flat surface at right angles to the leg. The Chirometer is placed with the triangular portion flush up against the medial tarsal area just in front of the medial malleolus (Fig. 7). The foot is held firmly and the patient stands on one foot. The Chirometer will be pushed with the medial roll of the arch. The amount of movement of the instrument is a measure of the pronation. The normal amount is $\frac{1}{8}$ inch.

Splaying of Metatarsals[3]

The foot is placed on the Chirometer with the first metatarsal head in direct contact with the upright triangular portion. A reading is then taken off weightbearing and another reading on weightbearing. The difference is the amount of splaying of the metatarsals.

Forefoot Drop[3]

For measuring "forefoot drop," the Chirometer is placed on the heel with the point aimed at the opposite heel. The angle of drop can then be measured in terms of degrees on the flexion and extension scales.

Tibial Torsion

The patient kneels on a chair. The slot of the triangular portion is laid over the tendo achillis. The degree of torsion can be read on the "flexion-extension" scales.

Some Observations

In the course of using this instrument in the past several years, I have noticed that in a considerable percentage of cases, deviation is more pronounced on one side than the other. Of approximately 140 children examined, 54% were in the 1 to 5 age bracket; 35% in the 6 to 11 bracket and 11% in the 12 to 17 bracket. Twenty-three percent had pronation more marked in one foot. In 49% the Achilles deviation was significantly greater on one side. In 30% the navicular depression was greater in one foot.

Summary

An instrument, the Chirometer, has been described. It is simple to use and is very useful in keeping a record of changes during the course of treatment and for measuring deviations.

Some observations on some findings have been made. It is hoped that this instrument will find value in the hands of the practitioner. Extensive use and reports of measurement obtained may produce a means by which some measurements can be standardized.

1407-1408 Central Tower

References

1. Schuster, R. O.: Address, Feb. 1953, Cleveland, Ohio.
2. Tax, H. R.: Podopediatric, p. 13, private printing, 1947.
3. Henenfeld, M., New York, suggests the method for measuring splayfoot and forefoot drop in a private communication.

"The simple cure for many states of disability is to give your mind a good shampoo every day."

—Dr. Sara Jordan
Co-founder the Lahey Clinic

A "Barefoot" Plantar Appliance*

Morton H. Walker, D.S.C.
Stamford, Conn.

WHEN there is pain anywhere on the plantar surface of the foot, the natural tendency of an individual is not to bear weight on that area. This favoring of a pain-producing part allows for rest to ensue so that the body process may come to its own defense and repair the damage. Frequently it is not possible for a person to rest the foot. Thus he continues to walk and work on the injured part. He walks with an unnatural gait and puts stress on muscles, ligaments and bones in the feet that are not in the habit of bearing weight. These structures in turn cause symptoms that add to the burden of walking and increase the abnormality of gait.

In order to relieve the stresses and strains of abnormal gait caused by local pain symptoms on the plantar surface of the feet, appliances have been used. The one here described can be adapted for almost any situation.

This foot appliance differs from others of a similar nature in that it can be worn directly on the bare foot, held in place by a heel-cupping at the rear so as to prevent slipping. It is kept in direct contact with the sole by an elastic band over the instep or held in place by the stocking alone.

This appliance consists of a felt pad impregnated with latex, cut to the shape of the foot. It extends from the postero-inferior border of the heel and runs forward to terminate at the toe webbings. It is shaped in the rear to cup the heel along its lateral, posterior and medial borders so that during gait the appliance is prevented from sliding forward or to one side. The heel cupping is achieved by the latex impregnation or by the incorporation of more rigid plastic material to achieve the degree of rigidity desired.

Raises or depressions may be made part of the basic felt pattern to incorporate whatver features are needed. Some are:

1. In the case of a pronated foot an additional felt raise of ¼ inch thickness (more or less) may be added to the inner longitudinal arch of the basic felt pattern.

2. In the case of "depressed metatarsal arches" with or without painful callus formation on the ball of the foot, the basic felt pattern may be cut out at the site of the "dropped" metatarsal to allow that part to "float."

3. In the case of a calcaneal spur, a doughnut or horseshoe-shaped pad may be added to the heel seat of the basic felt pattern.

Others will come to mind readily.

Various materials can be used in the construction of this barefoot appliance. Our experience is that cotton or wool felt is best, causing the least irritation to the skin, the least odor, the best absorbent power, the most washable, the longest wearing and the lightest weight. One problem with felt is its bulkiness. Other materials which can be incorporated as additions or reinforcements, are cork, sponge rubber, foam rubber, rubber butter (wood flour and latex, or ground cork and latex), leather, celastick heavy cloth, various synthetic fibers, fiberglass and various plastics. Some of these can be used to replace the felt.

The appliance is tailored to the individual patient problem. Felt paddings, surfaced with rubber cement, are applied as one would ordinarily and held in place with conventional or other adhesive strapping. On the patient's return in a few days, the pad is removed and only the excessive adhesive strapping is trimmed away. More padding of desired thickness and at desired areas is added and the whole reapplied to the patient. This is repeated

*Condensed from paper submitted in the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1960.

until in the operator's judgment, the desired thickness and shape to relieve the painful area is obtained.

The entire planta of the foot is now covered with 1/16 inch or thicker felt (necessary heel raises can be incorporated). The padding worn by the patient is made part of this felt covering. The felt is large enough to be cupped around the heel. The edges are, of course, beveled. The entire device is rubber cemented and strapped to the foot with adhesive tape. Care must be taken to adhere the felt well around the heel to obtain a good heel cup. The padding is removed in a few days. The pad has now taken on the entire contour of the foot being treated. This is trimmed so that it will take up as little room in the shoe as possible, coated by brushing on a very light natural or synthetic layer of latex and baked in an oven until dry, a matter of a few minutes. It is then coated with rubber cement and covered with monk's cloth. Nylon, leather, linen, or other materials may be used for covering. It may be stitched or cemented at its edges. It can be additionally covered with a synthetic fiber material such as nylon to make it more washable and durable. It is worn on the foot next to the skin, cupped around the heel and held on by the hosiery. An elastic band running over the instep of the foot can be added.

The appliance is washable in mild soap suds and warm water. It should be powdered daily. Its durability depends on the amount of wear an individual gives it and the amount of perspiration. Antiperspirants should be used on the feet from time to time. The only thing that really wears on the product is the cover and this can be replaced readily.

This device permits the podiatrist to fashion a plantar appliance on the foot of the patient. It is a dynamic appliance that molds itself to every contour of that foot. The patient can advise immediately as to whether a "correction" is comfortable or not. This appliance differs from the conventional device in that it is worn directly on the bare foot, although it may be worn in the shoe. It is soft and flexible. It is washable by the application of a sudsy sponge. The cost of materials is very low.

It may be made in multiple shapes, raises, depressions, cutouts, buildups, widths, thicknesses, lengths, colors and materials. It can be made to fit the extreme, dainty, high-heel, opera, dress pump or the high sided, hob-nailed, heavy-soled, waterproof, multilaced logger work boot.

1845 Summer St.

Ill fares the land to hastening ills a prey,
Where wealth accumulates and men decay.

Oliver Goldsmith
The Deserted Village

JOURNAL
OF THE
AMERICAN PODIATRY
ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

PUBLISHED UNDER THE DIRECTION OF THE BOARD OF TRUSTEES BY THE
AMERICAN PODIATRY ASSOCIATION
3301 Sixteenth Street, N.W., Washington 10, D. C.
A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

President's Message

Yes, We Do Have a Personal Responsibility

Your international organization, your state organization and your local organization are truly and simply service organizations, manned and financed by you for the purpose of supplying you and me with the necessary tools to accomplish the task of greater scientific achievement, educational assistance, research, public education and information, allied health relations, etc. . . . all for the purpose of giving better care and service to the public we serve.

Our personal responsibility is exemplified in the amount of "rent" we pay for the privilege of having been given the right to practice our profession and live in the community which we have chosen.

Individualism must not be submerged. Social pressures of today's complex living do not excuse us from, but rather create a greater demand for, a greater exercise of personal responsibility.

The question is not, "What is my profession doing for me?" but "What am I doing for my profession and the people I serve?"

Council on Education
Forty-first Annual Report, 1959-60*

Herewith is submitted the 41st annual report of the activities of the Council on Education during the year 1959-60 and its deliberations during the last 4 days.

For the first time since the formation of the Executive Council, now the Board of Trustees, a working liaison was established between them and the Council on Education, by the appointment of a joint liaison committee consisting of members of the two bodies, which are in constant communication with each other. By this means, each was informed of the actions of the other, and many possible duplications of effort were avoided and all possible areas of difference were ironed out so that the two bodies have been able to work in complete accord for the best interests of our profession and the public.

The action of the 1959 House of Delegates in raising the dues so that the Council on Education could be provided funds with which to carry out a positive program of development and improvement in the field of education, made possible the program which is here outlined.

The major part of our work this year has consisted of an exhaustive examination of various methods by which we could accomplish the desired results, namely to improve the status of our schools and the education offered to our students and to strengthen both the schools and the profession by the development of programs for improved public information and increased student enrollment.

After the groundwork had been completed and many suggested ideas screened, it became evident that an interim meeting of the Council must be held. The meeting was held in Chicago on March 27, 28, 29, 1960. Present at this meeting, in addition to the members of the Council on Education, were our Secretary, Dr. Abe Rubin and our immediate Past President, Dr. George Guenzler, who gave freely of their thoughts and suggestions.

The primary accomplishment at this meeting was the development of programs for student selection which will be reported on fully later in the body of this report.

A committee was appointed to make a thorough investigation of the M. J. Lewi College of Podiatry, the situation existing at Temple, the future status of the Temple school and the possibility of assistance to the students still enrolled there. In order to conserve funds, Drs. Yale and Locke, who practice near these schools, were assigned this task.

This being the year for inspection of the Western schools, your chairman asked that the inspection of the two Chicago schools be held in conjunction with the interim meeting of the Council, as this would further conserve our funds. The formal inspection of the California College was cancelled because we were aware of the excellent condition of that school. Dr. Raymond Locke and your chairman were able, at different times, to visit the school and make an informal inspection and report at no expense to the association.

A number of changes in the Rules and Regulations of the Council, designed to better distribute the workload among its members, were instituted.

A full-scale discussion was held on the possibility of standardizing the names of the colleges and the issuance of a uniform degree. A special committee was appointed to work with a like committee from the Association of Chiropody-Podiatry Colleges. This committee has made a progress report at the present meeting and is continuing its work.

A very important change in the handling of the finances of the Council was accomplished. The Finance Committee was changed to a Committee of the Budget and given complete supervision over all the expenditures of the Council. This com-

*Presented to the House of Delegates, August 25, 1960, Chicago, Ill.

TABLE I

Examinations and Licensure

January 1, 1959 to December 31, 1959

SCHOOL	California		Chicago		Illinois		Ohio		Temple		Lewi		Reciprocity
STATE	P	F	P	F	P	F	P	F	P	F	P	F	
Arizona		1											
Arkansas									1				
California	12	7	1		1	5	3	15	2	1	2	1	
Colorado					2		1						2
Connecticut									2		4		
Dist. of Col.					1		1		3		1		
Georgia							2		3				2
Idaho								1	1				
Illinois			12		16				1				
Indiana			3	1	3		2						1
Iowa					2								
Kansas					1								
Kentucky			1		1								
Mass.	Beacon 1 Passed		1						5				1
Missouri			1		2	2							
Nebraska					1								1
New Jersey							2		4				
Nevada	1												
New Mex.							3						3
New York						1	1		1		30	2	
North Car.											1	1	
North Dak.					1								
Ohio					3		26	1	1				
Oregon	1												
Penn.			1				4	1	14				1
Rhode Is.			3										
Tenn.									1				
Texas					2		2		2				
Utah					1				1				
Wisconsin					1								
Canada Ontario					1		1						
TOTALS	15	8 34.7%	23	1 4.2%	39	8 17.0%	48	18 27.2%	42	1 2.3%	38	4 9.5%	11

States not reported: Florida, Louisiana, Maryland, Michigan, Minnesota, Manitoba

No examinations given or licenses granted in Alabama, Alaska, Delaware, Hawaii, Maine, Mississippi, Montana, New Hampshire, Oklahoma, South Carolina, South Dakota, Vermont, Virginia, Washington, West Virginia, Wyoming, and Puerto Rico, Saskatchewan, Alberta, and British Columbia.

mittee was also charged with the duty of developing, for the first time, a detailed budget for the operation of the Council. (At this House of Delegates, this committee worked very closely with the Budget Committee of the Board of Trustees and the Budget Committee of the Association.)

The first actions by the Student Selection Committee were taken at the March meeting. Dr. Brachman, who headed this committee, made a full report on the various plans that were selected for consideration of the many that this committee had studied. It was decided this work must be divided into two phases, one a crash program for immediate implementation and a long-range program. The crash program consisted of "pump-priming" whereby $5,000 of the funds allotted to the Council for the 1960-61 program was earmarked for the use of those schools matriculating a class in the Fall of 1960. Each school was asked to spend $1,000 of its own funds on the promise of the Council to reimburse them on their submission of evidence of proper use of this fund.

This crash program has already borne fruit. The results are contained in the complete reports of the committee of the Council and of the school officials.

The long-range program consists of three facets. The first is the Kuder D-interest tests, details of which have been published in the June issue of the A.P.A. *Journal* and also in Book B, the Committee Reports. It is our hope that we receive full cooperation at this convention in the preliminary application of this program.

A sampling will be made here at this meeting to establish standards for this test. It is hoped that at least 300 persons will work with us to make this possible. (270 members cooperated by taking the test.)

For the first time our profession will be keyed in a national battery of tests which will be given to hundreds of thousands of high school students throughout the United States. Furthermore, approximately 6,000 Vocational Guidance Counselors will, through these tests, become well acquainted with podiatry.

We were very fortunate in having Dr. William Selden, Executive Secretary for the National Commission on Accreditation, appear before us at the interim meeting, at his own expense, and offer to head a commission consisting of prominent men in the field of professional education to conduct a survey of our entire podiatry educational endeavors. We are indebted to Dr. Rubin for making this possible.

The Council felt that the study by this commission could benefit us in three ways. It might make possible fuller accreditation by Dr. Selden's National Commission; it might establish a basis for grants from philanthropic, educational and business foundations; it will create interest among educators assisting our student selection efforts. Also, it may point out to all of us the weaknesses in our educational system and methods by which these weaknesses may be corrected.

In short, we hope that the effect in our educational field may be similar to the impact of the Flexner Commission Study on Medical Education.

Contact was made with the American Medical Association, American Dental Association and American Osteopathic Association to determine what methods might be employed and what format was to be followed in creating exhibits for student selection. It became apparent, through a paper by Dr. Roland W. Ross (J.A.P.A., 50:7:554) of the Department of Health, Education and Welfare, "that (our) exhibit leaves much to be desired in the way of psychological appeal to counselors."

In the light of the present inadequacy of our material, it becomes most imperative that this need must be filled. Accordingly, a meeting was arranged by Dr. Raymond Locke, with Mr. Bradner, now Director of Public Relations of the American Osteopathic Association, whose problems are very similar to those of podiatry. Drs. Irving Yale and Ed Barron, together with Dr. Locke, met with Mr. Bradner, August 25th (during the A.P.A. Convention). We received some invaluable guidance and

briefing from this gentleman which we intend to put to good use. One fact became crystal clear—no worthwhile efforts or program along these lines can be engaged in unless funds are available to the Council to carry on such activity jointly or in cooperation with the A.P.A. Audio-Visual Council and Vocational Guidance Committee. Plans for such activity are now being formulated, but they cannot be consummated without adequate funds.

You have elected a Council on Education which is most willing and anxious to do all in its power to help in this vital area of student selection. Without your assistance in providing the necessary funds for our program, however, we cannot succeed. The answer and responsibility rests with you.

The following resolution has been presented to this House by the Council on Education:

WHEREAS: New properly trained doctors entering the field of practice are the life blood of our profession; and

WHEREAS: Present low student enrollment has seriously curtailed operating funds; and

WHEREAS: Our Chiropody-Podiatry Colleges do not have endowments available to make up deficits; and

WHEREAS: When present reserves are depleted the schools will inevitably be faced with a lowering of educational standards because of lack of funds to maintain them.

THEREFORE BE IT RESOLVED: That a committee be appointed by the President and the Board of Trustees, with the approval of the House of Delegates, to explore the following areas of information:

A. The extent to which the practicing profession is interested in maintaining and extending high standards of education.

B. The possible ownership of the schools by the profession, should present student selection programs fail to produce the desired result and the fund for Chiropody-Podiatry education fail to benefit the schools directly during the time of stress and the situation in the schools fail to improve.

The M. J. Lewi College of Podiatry petitioned the Council on Education for permission to hold a postgraduate course leading to the Doctorate Degree for the older practitioners of the State of New York only. They will be granted permission by the New York State Board of Regents to do so, upon approval by the Council on Education. The University of the State of New York is to issue the degrees. Dr. Schwarz was delegated to consider all facts pertaining to this course. He reported his findings together with a complete outline of the proposed course and after considerable discussion, permission for this course was granted by the Council on Education.

Meeting with Deans

A meeting was held with the deans of all the colleges with the exception of the M. J. Lewi College of Podiatry. Each of the deans reported on his experiences with our student selection program and presented us with their concept of an extension of this program. Dr. Pierce Nelson of California College of Podiatry presented us with an outstanding survey of the work they had begun in this area. The $1,000 granted to this school enabled them to embark on a program that has already cost them over $10,000. We know that results will be good.

All of the deans were encouraged to discuss their individual problems relating to transcripts, courses, etc. The general enrollment picture for the fall of 1960 appears to be somewhat brighter than it was last year.

Policy

The Council recognizes that a certain amount of leeway is necessary to effective education, but hopes to be able to set standards of reasonable uniformity of curricula to make certain that every man entering the field of podiatry shall be adequately prepared.

In order to do this the Council feels that it must have jurisdiction over every facet of podiatry education. In this respect the Board of Trustees has cooperated by turning over to us certain areas which in the past it had retained.

Liaison

Drs. Gennis and Schwarz met with the Board of Trustees in Washington in January 1960.

A second meeting of a special committee consisting of Drs. Brachman and Locke with a group appointed by the President was held in Washington to discuss various activities in preparation for the annual meeting.

An informal meeting was held in New York at the Foot Health Conference between Drs. Locke and Schwarz of the Council and Drs. Mullens, Nyman and Horowitz, at which time certain projected activities of the Council were discussed. This meeting, which was held at no expense to the Association, was quite fruitful.

Essentials Committee

One major change was made in the essentials. Since the Council on Education has been called upon at various times to evaluate the educational qualifications of applicants for admission to our accredited schools, and because of the difficulty arising from our attempt to evaluate foreign education according to American standards, the Council on Education has adopted the following rules of procedure:

A. Applicants for admission to advanced standing in accredited schools of Chiropody-Podiatry, who have had satisfactory pre-professional school requirements, and who present proper certificates of graduation from foreign schools of Chiropody, may be examined by the accredited school accepting them for admission, to determine their proper scholastic level. In no instance shall an applicant be admitted to a level higher than the Junior Class. He (she) must attend a minimum of 2 full scholastic years before being granted a degree. Each individual case must be reported to the Council on Education.

B. Graduates of a 4-year course in non-accredited American schools before 1957, who have had acceptable pre-professional requirements, and who after graduation from such a non-accredited school have passed satisfactorily a State Board examination, may be admitted to the Senior Class of an accredited school and must attend 1 full scholastic year to be eligible for a degree. Each individual case must be approved by the Council on Education and the applicant must appear before a Committee of the Council for screening.

C. Transfer students from accredited schools of medicine, dentistry, osteopathy, pharmacy and veterinary medicine who wish to enter accredited Chiropody-Podiatry Schools with advanced standing will be examined by the accepting school to determine proper scholastic level but in no instance shall they be admitted to higher than the Junior Class and must attend 2 full scholastic years to be eligible for a degree. Each instance of such admission shall be approved by the Council on Education.

It is suggested that the next Council study the essentials and make a complete revision thereof, inasmuch as certain of the other provisions have become outdated.

School Inspections

The Illinois College of Chiropody and Chicago College of Chiropody were inspected in March of 1960 immediately following the interim meeting of the Council on Education in Chicago. The inspection reports are on file with the secretary of the Council on Education and are available to any delegate on request for examination in the presence of a member of the Council on Education.

Transfer

The Transfer Committee handled the applications of five students who applied for transfer from one school to another. A special committee was formed to expedite the exchange of students from the Temple School to the New York and California schools. These students will return in June of 1961 to receive their degrees from Tem-

ple University. The usual correspondence was handled concerning inquiries from Canada and foreign countries.

Clinics Committee

We requested from each of the schools a survey, broken down into the number of patients seen in the clinics, number of students in attendance, average number of hours each student spends in clinic; number of clinicians assigned to clinics and average number of hours in attendance; number and type of non-professional help and their average hours.

Replies were received from all schools except the M. J. Lewi College of Podiatry. These statistics have been filed with the secretary of the Council on Education.

Finance (Budget)

As has been mentioned before, the Finance Committee, in addition to making a study and analysis on the financial reports of the colleges, has been given additional duties:

1. Supervision of all expenditures by and for the Council, and

2. The preparation of a projected budget for the operation of the Council for the following year.

The budget as originally prepared called for expenditures in the fiscal year of approximately $28,000.00. After conference with the Board of Trustees and by agreement between the two groups, the total was reduced to $22,000.00. Then, by reassignment of the Career Guidance Program and with liaison between the two groups, an additional reduction of $3,000.00 was made. The final budget reached was $19,300.00.

The Council on Education having committed $5,000.00 for the "Crash Program" on Student Selection to the schools and an expenditure of $1,867.30 for the interim meeting in March of this year, and for expenses of the Council since the end of the past fiscal year, resulted in a net operating budget of $12,432.70. This amount, in our considered opinion, will not give the Council on Education the sum needed for the desired effective program as planned. The Budget Committee is of the opinion that it is utterly impossible to pursue the full program you so earnestly desire with the revised budget. With this curtailment we will render the services desired to the best of our ability with the funds made available by this House of Delegates.

The detailed financial reports of the schools with analysis by the financial committee are on file here and available for inspection. We wish to note here the improvement in the cooperation extended the Council by the schools. In almost every case, information asked for was forthcoming in a reasonable time. Cooperation from the National office was most outstanding. Dr. Rubin, Dr. Nyman and the entire Washington staff have given us help far beyond the normal call of duty whenever called upon.

Career Guidance Information Furnished

In the past several years the Association has had an exhibit at the Annual Meeting of the Personnel and Guidance Association with which is associated the National Vocational Guidance Association. Mailings have also been sent in the past several years to the members of these associations. Resulting from this, a large number of the high schools, junior colleges and other institutions now have information in their libraries on careers in podiatry-chiropody. We have also been able to arrange for the inclusion of information on our profession in a considerable number of guidance publications.

As a consequence of these activities, national headquarters receives many requests for guidance information from all over the United States from guidance counselors, prospective students, librarians and others. Regularly a distribution list of inquiries is mailed to state societies and our colleges for follow-up to the individual requesting the information.

Table on the page opposite provides a breakdown by state and by category of requests received and filled for the year beginning February 1, 1960, ending January 31, 1961. The total requests received and filled were 1,447.

CAREER GUIDANCE REQUESTS RECEIVED FROM FEBRUARY 1, 1960 THROUGH JANUARY 31, 1961

The following is a classification breakdown of requests received for literature and information by individual States during the past year:

States	Guidance Counselors	Prospective Students	Librarians	Children	Other
ALABAMA	11		1		3
ALASKA		1			
ARIZONA	12		2		
ARKANSAS	10	2			
CALIFORNIA	51	20	32	3	
COLORADO	9			1	
CONNECTICUT	25	3	1	1	1
DELAWARE	2	1			
DIST. OF COLUMBIA	9		1	1	
FLORIDA	46	12	3	1	3
GEORGIA	17	6			
HAWAII	2	1			
IDAHO	17				
ILLINOIS	21	8	17	1	2
INDIANA	29	4	7		2
IOWA	25	6	3		
KANSAS	18	3	3		2
KENTUCKY	7	3			
LOUISIANA	3	2			
MAINE	8				
MARYLAND	14	8	4		4
MASSACHUSETTS	22	9	5		1
MICHIGAN	54	6	7		3
MINNESOTA	28	4	8	2	1
MISSISSIPPI	6	2			
MISSOURI	40	5	2		1
MONTANA	7				
NEBRASKA	6		1		
NEVADA	2				
NEW HAMPSHIRE	3	1			
NEW JERSEY	43	11	5	2	6
NEW MEXICO	8		1		
NEW YORK	110	69	12	2	12
NORTH CAROLINA	38	2	2	1	9
NORTH DAKOTA	2	1			
OHIO	43	9	6		6
OKLAHOMA	12	3			
OREGON	7	1	8		
PENNSYLVANIA	53	15	10	8	20
RHODE ISLAND	1	1	1		
SOUTH CAROLINA	10		2		
SOUTH DAKOTA	7				
TENNESSEE	12	1	4		
TEXAS	29	6	5		
UTAH	2	2	1		
VIRGINIA	18	3	2		1
VERMONT	2	1			
WASHINGTON	11	4	5		
WEST VIRGINIA	10	3			
WISCONSIN	10	1	5	1	
WYOMING	3				
APO ADDRESSES	1	2			
U. S. POSSESSIONS	1				
FOREIGN		1			
TOTALS	937	243	166	24	77

Insurance Needs of the Professional Man

At my request, Mr. Leonard Zimmerman, the Insurance Counselor of the A.P.A. has conferred with other experts in the fields of general and personal insurance and offers the following suggestions. These are not intended as a blueprint but to point up some areas of protection that deserve consideration.

General Insurance

Each of the 50 states has different insurance laws and regulations so that some of the suggestions may not apply to you specifically. Your general insurance agent or broker can advise you how to adapt them to your own needs. The approach to the writing of all insurance coverages for the professional man is basically determined by whether he practices from an office in his home or from a separate location.

If the office is in his home, then "package" insurance is available which combines fire insurance on the building and contents including professional equipment, with burglary and theft, additional living expenses and even comprehensive personal liability and medical payments. As might be expected, the cost of this "package" policy is generally around 20% less than the cost of separate policies. Very often coverage is broader than can be secured even under higher cost individual policies. There are at least six types of "package" policies ranging from the limited but basically adequate "bread and butter" Homeowner's A, still available in some states including New York, to various "all risks" forms.

If the office is at separate location from the dwelling (or apartment) then separate policies are required. But here too there is a choice from the basic fire and extended coverage form (hurricane, explosion, etc.) to the "all risks" Physicians and Surgeons Equipment Floater. Surprisingly, the Physicians and Surgeons Equipment Floater which combines fire, hurricane, explosion, water damage, burglary and theft, etc., may also work out cheaper than the cost of separate policies providing less coverage. The premium is based on the basic fire rate plus a loading which is the same in most states and which reduces as the amount of insurance increases.

Certain basic principles suggest themselves in any event. First is the importance of having an inventory of the property insured. Regardless of the type of insurance carried or the company, it is necessary for the insured to provide an itemized statement of loss in substantiation of any claim. Obviously it is much easier to do this before the loss than after. This is also the only way to determine the proper amount of insurance which should be carried and to prevent over or under insurance. One word of caution in figuring values—book or valuation for tax purposes is not insurable value. The amount to be insured is "actual cash value" which is defined universally as the replacement cost less depreciation. While there is no rule of thumb for determining depreciation, it may often work out that the actual replacement cost less a figure of, say 20%, will be found workable. This would not hold if all the property were new or very old. (Of course, keep the inventory, but in another place so it won't burn up with the property.)

Another basic principle involves carrying high enough limits of liability. Many insurance people and attorneys feel that $100,000 per person and $300,000 per accident are a minimum. Some advise that limits of $250,000 per person and $500,000 per accident are safer. In an upstate New York county within the past year, a judgment was awarded against a landlord for $600,000 for injuries to one person.

Some other pointers: If ordinary fire and extended coverage are carried, check to see if the very inexpensive vandalism coverage is included. If you practice from a separate office, do you have extra expense coverage? Consider the low cost of an office burglary and robbery policy which can be written for as little as $14.00 a year and covers up to $250.00 against inside robbery

and theft, safe burglary, holdup outside the premises, theft from the residence, and damage to the premises or equipment as a result of an attempted burglary or theft.

Even if your state does not require Compensation, and many states do, even for one part-time employee, consider taking it out voluntarily. Several states now require that you carry non-occupational disability benefits for as few as two employees.

Personal Insurance

The economic role of the podiatrist is that of a dual businessman: He has his professional business and his family business and he must balance his finances between the two.

Unlike a retail merchant or manufacturer, however, his income is entirely dependent on his ability to be on the job. The businessman can be away from his desk for a considerable time, yet his employees continue to produce income for him. Let the professional be away even one day and his total income for that day ceases. Therefore, it is essential to provide disability income to replace this loss.

The inexpensive disability income insurance available under the A.P.A. program is indispensable for every member. Since disability income payments are received tax-free, it is not necessary to insure 100% of your net. We recommend that you cover yourself to a maximum of 75% of your net before taxes. At present the maximum protection available under the A.P.A. program is $400.00 per month. If you need more coverage I suggest you consider securing additional insurance from one of the excellent companies offering individual non-cancellable, guaranteed renewable insurance. Consult our A.P.A. insurance administrators at NAC Agency for information and rates.

Another method of protecting your family income is through the use of Office Overhead Expense disability insurance. This low cost form of protection will provide payment for your regular office expenses, exclusive of your personal drawings, for a period of one year. This normally is the length of time you will require this protection since, if a disability is prolonged beyond that time, it is unlikely you would continue to keep your office in operation. Incidentally, premiums for this are tax deductible as a business expense. The A.P.A. will sponsor a group plan for this coverage in the very near future.

Medical Expense Insurance

A prolonged disability involves not only loss of income but usually considerable medical or hospital expenses as well. It is important to guarantee that income is available for the family's day-to-day needs, and is not eaten up by medical bills.

The most effective way to do this is to secure some form of basic hospitalization insurance to cover the entire family and to protect them against the financial ravages of serious illness or injury through the Major Medical Plan of the A.P.A. This will protect each and every member of your family for up to $10,000—and its cost is very low.

Health Insurance for Your Assistants

Should your assistant become injured or ill you would probably continue the salary for at least a limited period of time. This can become quite an expense, particularly if it is necessary to secure a temporary replacement. A far more practical method is to buy disability income insurance for her and pay the premium yourself.

Under the present Internal Revenue regulations you are permitted to deduct the premium paid by you for your employees as a business expense so that your cost is reduced by the tax credit. This is an attractive extra benefit to your employee who is assured of your interest in her welfare. In most cases it will mean more than a small salary increase, in terms of real income. For information about rates write the NAC Agency giving ages and amounts of coverage desired for each of your assistants.

Life Insurance

I am certain that every podiatrist is aware of the importance of providing adequate life insurance to protect his family. Consequently, I do not propose to discuss here either the necessity for it nor to recommend specific forms or amounts of insurance. If you have not recently reviewed your personal program I suggest you do so with the advice of a competent life insurance counsellor.

Today, however, many podiatrists practice in association with one or more colleagues either in formal or informal partnership. This presents special problems which deserve consideration.

Since income from such an association is the result of the joint efforts of the partners, the untimely death of one of them creates serious difficulties. If a partnership exists it is *legally* terminated by the death of one of the partners. The surviving partner is under *legal* obligation to liquidate the assets of the partnership at once, to account to and to turn over to the estate of the deceased partner its share of the proceeds. In the absence of a formal agreement to continue the business the surviving partner has no right to continue the practice but must first settle the partnership affairs.

Volumes could be written about pitfalls and disasters that follow such an event—but just consider a few of them—all partnership equipment and assets must be sold at the best possible price. It is unsafe for the surviving partner to buy it for his own use since he must act as a trustee for the partnership and must deal with potential buyers as a representative of his deceased partner. If he fails to get a good price—and you know what used equipment is worth in the event of a forced sale—he may be liable to his partner's estate for the difference in value. Further, if he sets up his own practice he must again buy the equipment he needs—and replacement costs today are high. He may not draw money from the partnership until its affairs are all liquidated and this would unquestionably impose a hardship on him particularly if it takes time to accomplish. For other harrowing details ask your own attorney.

It is easy to avoid such difficulties, however, through the creation of a "Buy and Sell" agreement between the partners, backed up by life insurance to guarantee its fulfillment. In a typical arrangement of this kind each partner agrees to purchase the partnership interest of his associate, should he die, at an agreed price (it may be a fixed amount or be based on a formula) and purchases sufficient life insurance on his partner's life to provide the funds necessary. At his partner's death he pays the proceeds of the life insurance to his partner's estate in exchange for the partner's interest. He pays no income tax on the insurance proceeds and winds up with full ownership of the partnership assets without complications. His deceased partner's estate is assured of receiving a fair payment for the value of its interest, not subject to the ravages of forced liquidation, administration expenses, delays and possible lawsuits.

This is a simple, effective, inexpensive solution to the problem. In most instances the cost of such insurance is not more than 2% a year of the value of the partnership interest — yet it provides 100% peace of mind and security. If you are a member of a partnership or association and have not yet protected yourself in this way, I urge you to consult your insurance counsellor or the Podiatrist Planning Service of the NAC Agency for the best way to protect yourself.

Obviously, all problems cannot be anticipated or covered and certainly, all solutions cannot be offered in a brief article of this type. However, perhaps we have stimulated you into taking a more interested look at your present program.

There is no substitute for a good insurance agent or broker.

I. Pashin, Pod.D.
Chairman for Insurance Services
Council on Membership Development

Organization News

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

California

The 1961 Region 12 meeting and Western Podiatry Congress will be convened at San Francisco's newest hotel, the Jack Tar, on May 26th and 27th. The features will include a stimulating scientific meeting and an unusual and entertaining social program. Members who have new ideas to share will be interested in the Hall of Science. Scientific exhibits may be shown and there will be no charge for booth space. Contact Dr. David Y. Chan, 2107 Van Ness Avenue, San Francisco, for an application for space.

Connecticut

Dr. Michael V. Simko of Bridgeport received a "service to his profession" award at the annual meeting and installation of officers of the Connecticut Podiatry Association in New Haven, January 23rd.

Michigan

Mr. Fitzke visited Washington to meet with Senator McNamara in regard to the question on our profession in the Department of Labor.

New Jersey

A number of members of the New Jersey Chiropodists' Society, from all sections of the state, toured the Ciba plant in Summit, N. J., to investigate their latest therapeutic techniques in the use of pharmaceutical products in the treatment of foot disabilities.

Dr. A. J. Muccioli of Trenton visited Washington to meet with his Congressman and Senator.

New York

The Podiatry Society is pleased to announce two excellent foot care stories which identify the podiatrist as the foot specialist

Awards for Research Papers

The Wm. Stickel Annual Awards
for Research in Podiatry-Chiropody for 1961

Sponsored by the
Journal of the American Podiatry Association
and
The NAC Agency, Inc.

Seventeenth Year of Awards
Gold Award - $400.00 — Silver Award - $250.00
Three Bronze Awards - each $75.00

THE DREW AWARDS

For research on the practical application of shoes to foot problems.
1st Award - $200.00 — 2nd Award - $150.00 — 3rd Award - $100.00

Application forms, rules and regulations can be obtained from the Secretary. The final date on which papers will be accepted is May 1, 1961.

and the authoritative source of information on all aspects of foot care. The first story appeared in the Antoinette Donnelly column, the largest syndicated column of its type in the country. The New York outlet is the *Daily News*, the nation's largest newspaper.

The article headlines "Podiatrists Counsel on Winter Foot Care" and contained frequent mention of podiatry and foot specialists. It will serve as an excellent medium for public indoctrination as to the need for regular podiatric care.

A forthcoming issue of *Scholastic Magazine* will feature a special teachers guide on foot care. The materials will be sent by the publisher of *Scholastic* to all home economics teachers and administrators in the country. The advance proofs of the story were bylined "Adapted from materials prepared by the Podiatry Society of the State of New York." Our suggestion to the editors was that the article also contain mention of the literature prepared by the Podiatry Society and its availability for classroom use. It is anticipated that this additional material will be incorporated in the body of the article.

North Carolina

Midwinter meeting of the North Carolina Podiatry Society was held in Southern Pines, January 28 and 29, 1961. Dr. John T. Sharp of Abington, Pennsylvania, presented a series of illustrated lectures on podopediatrics. Principal speaker at the banquet was Mr. Malcolm Seawell of Raleigh, North Carolina. Out-of-state visitors were Dr. Owen Penney of Washington, D. C., and Dr. and Mrs. Sam Kaufman of Martinsville, Virginia.

At a business meeting three new members were added to the rosters and the state dues were increased with a special provision for newly graduated practitioners.

Pennsylvania

Philadelphia Chiropody Society

James C. Giuffré, M.D., Medical Director and Chief of Surgery, St. Luke's and Chil-

Beaver CHISEL BLADE KNIFE

UNIFORM • STURDY
DEPENDABLY SHARP

The six shapes of blades are designed for use primarily in podiatry, although they are adaptable to other surgical procedures. Made of fine-grained Swedish steel, Beaver Chisel Blades are keenly edged and extremely hard for longer life. The handles are solid stainless steel or plated brass, utilizing the simplest collet-locking device possible.

5 Blades per Pack—24 Packs per Box
Nos. 81, 82, 83, 84 per Pack $.75
Nos. 86, 88 ..... per Pack $1.00
Stainless Steel Handles #4S $2.50
Plated Brass Handles #4P $1.25

SURGICAL KNIVES BY Rudolph Beaver

WALTHAM 54, MASSACHUSETTS

dren's Medical Center, and Dean, Philadelphia College of Chiropody, recently received a Certificate of Honorary Membership in the American Podiatry Association in recognition of his contribution to the profession of Chiropody (Podiatry). The Resolution conferring the Honorary Membership was adopted by the 1960 House of Delegates.

The presentation was made by Arthur E. Helfand, D.S.C., St. Luke's staff chiropodist and national chairman of the Advisory Committee on Civil Defense and Emergency Medical Care of the American Podiatry Association, at a joint meeting of the Philadelphia Chiropody Society, North Philadelphia Chiropody Society and the Delaware County Chiropody Society at the Philadelphia County Medical Society Building.

Dr. Giuffré was graduated from LaSalle College in 1935, and received his M.D. degree from Hahnemann Medical College in 1939. He took his postgraduate study in surgery at the University of Pennsylvania Graduate School of Medicine. He is a Fellow in the International College of Surgeons and a Diplomate and member of the Board of Governors of the American Board of Abdominal Surgery. He holds membership in the American Medical Association, Philadelphia County Medical Society, Pennsylvania State Medical Society, American Association of University Professors, New York Academy of Science, American Public Health Association, Pennsylvania Academy of Sciences and the American Association for the Advancement of Science.

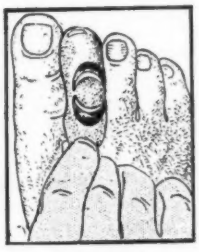
Western Division

The Western Division met January 11 to hear Mr. Leslie I. Cohen, attorney, discuss "Malpractice."

At the February 9 meeting a panel of local chiropodists gave practical practice techniques: Dr. Haber—a different plantar pad; Dr. Wolf—quickly and easily made stainless steel tray for footrest of operating chair; Dr. J. Keener—types of chiropody padding; Dr. A. Schultz—adapt improper fit shoes to the patient's feet.

FOR THE FINEST IN LATEX SHIELDS

CUSTOM BUILT PROSTHETICS DESIGNED AND TAILORED
BY CHIROPODISTS FOR THE CHIROPODY PROFESSION
TO CASTS OR IMPRESSIONS



Hammer Toe

Bunion
and special types

Heloma Durum

LIQUID RUBBER APPLIANCE LABORATORY

45 Valley Way **West Orange, N. J.**

Prompt Service Send for brochure

Both meetings were held at the Hotel Pick-Roosevelt.

Rhode Island

The Rhode Island Podiatry Society was invited to send representatives to attend the Rhode Island Administrators Conference on School Health. The Podiatry Society has high hopes of playing an important part in the further development of these school health conferences.

Tennessee

Dr. Bernard J. Hersh of Dallas, Texas, was guest lecturer at a meeting of the Memphis Chiropody Association held in November, presenting a series of slides on surgery. This was followed with a workshop on anesthetic techniques.

Academy of Podiatry

At a meeting of the Academy of Podiatry at Hunter College on January 10th, Dr. Abel Gorfain was elected President; Dr. Milton D. Roven, Vice President, and Dr. Louis Lewy, Secretary-Treasurer. Members of the Board of Governors will be Benjamin Brody, Alexander Goldschmidt, Sidney Kaplan, Mario Miletti, William Reife, Samuel Rosoff, Ralph Tassini, Milton Windt and Arnold Pinsker. Dr. Brody is chairman of the scientific committee.

This is the 44th time that Dr. Lewy has been elected Secretary-Treasurer. The main function of the Academy is to render scientific knowledge and aid in the research of the foot.

A.S.C.R.

The anual postgraduate symposium of the American Society of Chiropodical Roentgenology was held January 14th and 15th at the Schine Inn, Chicopee, Mass. Speakers on the panel were: Drs. Vincent Jablon of Danbury, Conn.; Raymond Locke of Englewood, N. J.; Morton Polokoff of Paterson, N. J.; and Gerald Hoag of Springfield, Mass., who was chairman of the symposium.

The luncheon meeting was conducted by A.S.C.R. President Healy of Westfield, Mass. It was suggested at this time that the society name be changed from "American Society of Chiropodical Roentgenology" to "American College of Foot Roentgenology." A very interesting workshop session was conducted in the afternoon with time allotted to discuss difficult cases in detail.

Write to Headquarters for Information

YOUR DOLLARS FIGHT... for crippled children

1961 Easter Seals HELP CRIPPLED CHILDREN EASTER SEALS

National Society for Crippled Children and Adults
2023 W. Ogden Ave.
Chicago 12, Ill.

Women's Auxiliary Message

Dare and Do

The dare is first to make the resolution and then to go ahead and do! There is so much that must be done, so many great opportunities for the podiatry profession to plan for and carry through to their conclusion.

One of these very important plans is to aid our podiatry colleges. I dare you to make the resolution first to send your contribution direct to the college of your choice or direct to the Fund for Podiatry-Chiropody Education. Now that the resolution is made, Do It!

If we, within the profession, are not willing to do our share, we certainly cannot expect those outside the profession to help with their contributions.

I urge you to DARE and then DO!

Mrs. Cleotha Parham, President

BUTLER'S CHIROPODY SUPPLY CO.

Specialists in the Finest
All Nationally Advertised Equipment

SURGERY TABLES
AUTOCLAVES
STERILIZERS
ULTRASOUND
SINES & DIATHERMIES
WHIRLPOOLS
X-RAYS
CABINETS
CHAIRS AND STOOLS
LAMPS
DRILLS

INSTRUMENTS
CHIROPODY
SURGICAL

SUPPLIES

Arch Appliances made to specific prescription and cast work

Materials also stocked for making your own arch appliances.

5541 York Blvd., Los Angeles, Calif.
CLinton 5-3049

1089 Market St., San Francisco 3, Calif.
UNderhill 1-4551

BUTLER'S

"The House of Friendly Service"

TERMS TO SUIT

WRITE FOR PRICES AND DETAILS

FOOT BALANCE INLAYS

are only completely
successful
when each case
is individually studied, diagnosed
and an inlay made to fit its
special requirements

The laboratory of

CARL G. BERGMANN, D.S.C.

5406 BROADWAY **CHICAGO 40, ILL.**

originator of foot balance inlays is directed
in all its endeavors to accomplish this result

Deaths Reported

Amiel Caplan
New York, N. Y.

Charles M. Blumenthal
Chicago, Ill.

Ted Bowen
Dallas, Tex.

William D. Buchanan
Abilene, Tex.

Melvin M. Ebert
New York, N. Y.

Irving Gersten
New York, N. Y.

Anthony H. Mango
West Hempstead, N. Y.

Caroline Meier
Chicago, Ill.

Christa B. Milspaugh
Corning, N. Y.

Glen Mack Fishburn

Dr. Glen Mack Fishburn, the first podiatrist to be licensed in Utah, passed away February 3, 1961 of a heart ailment. He was a graduate of Illinois College of Chiropody, 1925, starting into practice in Ogden, Utah, in that year. He was born December 15, 1900 in Brigham City, Utah, and married Ella Mae Harper in 1920.

Surviving are his widow, his son, John, who had been associated with him since 1951, a daughter, Mrs. Junior Squires, nine grandchildren and two brothers, Raymond and Noble.

Ohio Students

The senior class of the Ohio College of Chiropody spent 3 days, January 15, 16, 17, as guests of the Upjohn Pharmaceutical Company in Kalamazoo, Michigan. They visited the research plants and production facilities. Several members of the faculty accompanied the senior class.

THE HOUSE OF COMFORT

known for

Their outstanding, skilled craftsmanship in the appliance of old-fashion and modern hand-made foot appliances for any kinds of deformity as well as Balance Inlays, Levy and Sansone Molds, Celastic, and arches of oak sole leather with blue tempered steel springs; also flexible type of supports of cork and rubber.

We also construct any type of stainless steel plates.

The priceless knowledge and experience which we learned and inherited from our fathers enable us to be very proud of our scores of years in orthopaedic work.

Every appliance constructed in our laboratory is hand made. We DO NOT HAVE ANY STOCK APPLIANCES OF ANY KIND.

It is our proud privilege to serve you and the profession in your every need and we look forward to hearing from you in the near future. Write for our literature.

LEVY & RAPPEL, INC. *The home of individual orthopaedic appliances*
384 COLUMBUS AVENUE **NEW YORK 24, N. Y.**

Dates to Remember

EVENTS

Youth Fitness Week
April 30-May 6, 1961. Sponsored by President's Council on Youth Fitness.

Foot Health Week
May 14-20, 1961. Sponsored by American Foot Health Foundation.

Youth Foot Care Week
Oct. 15-21, 1961. Sponsored by American Foot Health Foundation.

MEETINGS

American Podiatry Association
Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J., Apr. 27-30, 1961
Ambassador Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
Columbus, Ohio, May 18-20, 1961
Deshler-Hilton Hotel
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Dr. W. D. Canada, Pres.
1812 Nichol Ave.
Anderson, Ind.

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Des Moines, Iowa, Apr. 7-9, 1961.
Savery Hotel
Drs. Stewart E. Reed and Ralph C. Kirkwood.
425 Kresge Bldg., Des Moines, Iowa

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)
Portland, Ore., May 5-7, 1961.
Sheraton Hotel
Vance A. McNish, Convention Chairman
1218 Selling Bldg., Portland 5, Ore.

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine
(Florida)
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E.
Atlanta, Ga.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Fort Worth, Texas, June 14-17, 1961
Hotel Texas
16th Southwestern Chiropody Congress
44th Annual Convention of Texas Society
Dr. Joseph R. Ordile, 111 Professional Bldg.,
Ft. Worth 4, Tex.

Region Twelve
(Ariz., Cal., Nev., Utah)
San Francisco, Calif., May 24-28, 1961.
Jack Tar Hotel
David Y. Chan
2107 Van Ness Ave., San Francisco, Calif.

International Union of Podology
Second International Congress.
Belgium, France, W. Germany, Holland, Spain, Switzerland, Argentina, Sept. 8-12, 1961.

FREE —18-Page Catalog
ESSENTIALLY AN ENCYCLOPEDIA
of Professional Foot Appliances
including MATCHED PARTS for your own office assembly.
Your copy mailed promptly upon request.
SAPERSTON LABORATORIES
ESTAB. 1918
22 W. Madison St.
Chicago 2, Ill.

Mood Elevators

Contributions to this column are more than welcome. In fact it depends upon them. A.O.P.

Idle thoughts on an idle day

Ever try describing a man playing an accordion while descending a circular stairway? With your hands in your pockets?

Confucius say: "Sheriff who use water pistol sure to get drop on outlaw."

TV Pantomime Quiz

Signs

On a television repair shop: "Do it yourself—then call us."

On a cigar counter in a tobacco shop:

Fight Cancer
Stop Smoking

Definitions

An egotist is one who is always me-deep in conversation.

DR. POD By Bob Hughes

"Charles—Are you sure there is nothing wrong between you and the Bureau of Internal Revenue?"

Time Marches On

Remember the good old days when charity was a virtue instead of an industry?

A nail lacquer specifically formulated for fungus of the nails

KERALAC

The active ingredient of Keralac is the powerful fungicide chloranil which has been used under the name of Spergon® to protect growing crops against attack by soil fungi. It was found that incorporating chloranil into a nail lacquer provided a satisfactory vehicle for treating fungus of the nails for it was thus held in close and intimate contact with the nail.

The result is Keralac. The concentration of the fungicide is 0.5%, but when the lacquer dries the concentration rises to around 2.5%. Keralac is particularly indicated in a distal fungus infection.

Keralac is non-staining and non-discoloring. It is cosmetically elegant and when dry has the smooth and shiny appearance of a nail lacquer. Further, the painting of a nail with a lacquer is readily accepted by the patient.

Available ¼ oz. bottles complete with brush applicator.

Samples and literature on request. ®Trademark United States Rubber Company.

References:

1. McGavack, T. H.; Wiener, D.; Bell, M. and Boyd, L. J.: Archives Dermatology and Syphilology **59**, 94 (1949).
2. Rankin, J. L.; Dobes, W. L.; Jones J. W.; and Alden H. S.: Southern Medical Journal **44**, 616 (1951).
3. Gordon, M. A.: Archives Dermatology and Syphilology **66**, 573 (1952).
4. Moore, M.: Archives Dermatology and Syphilology **66**, 621 (1952).
5. Teichmann, W. O. and Horwath, P. N.: Southern Medical Journal **50**, 1521 (1957).
6. Hoffman, H. L. (Washington, D. C.): Personal communication.

SALEM PHARMACEUTICALS **Naugatuck, Connecticut**

ADVERTISERS INDEX

Alden Shoe Company, C. H. 171
Armour Pharmaceutical Company 158
Baltor Bracelet 227
Beaver Company, Rudolph 220
Bergmann, Carl G. (D.S.C.) 223
Birtcher Corporation, The .....4th Cover
Butler's Chiropody Supply Co. 223
Cooper, Tinsley Laboratories 159
Dome Chemicals, Inc. 167
Edwards, The Shoe for Children 181
Foot Facts Publications 228
Foot-So-Port Shoe Company 157
Fougera and Company, Inc., E. 179
General Aniline & Film Corp. 161
Lakeside Laboratories, Inc. 163
Levy & Rappel, Inc. 224
Liquid Rubber Appliance Laboratory 221
Maltbie Laboratories Div. 175
NAC Agency, Inc., The 176
National Drug Company 228
Personal Contour Shoe Co. 165
PodiatRex, Ltd. 182
Region 3 172
Salem Pharmaceuticals 226
Saperston Laboratories 225
Sardeau, Inc. 177
Satisfactory Shoe Company 173
Surgical Supply Service 228
Westwood Pharmaceuticals .....2nd Cover
Winthrop Laboratories .....169, 3rd Cover
Wynlit Pharmaceuticals, Inc. 178
Zotox Pharmacal Company 180

troubled toes! . . . give them a chance to breathe . . .

Baltor Bracelet, 3800 Poplar Ave., Brooklyn 24, N. Y.

The Audio-Visual Council Announces

A Dramatic New Filmstrip

FOOT HEALTH

32 frames in full color with a 33⅓ rpm unbreakable vinyl record

1. Completely New
2. Depicts Many of the Common Foot Problems
3. 32 Frames in Color
4. Unbreakable Vinyl Record
5. Written Script

EXCELLENT FOR YOUR PUBLIC EDUCATION PROGRAMS

Can Be Used For: High School and College Classes
Industrial Health
Geriatrics
P.T.A.'s

TOTAL PRICE: $12.00 plus mailing costs
Write APA Headquarters for your kit now

NOTE: This complete kit is also available in 32 individual mounted 2x2 slides with 3-3/4 tape recording: PRICE: $20.00 plus shipping charges.

CLASSIFIED ADVERTISEMENTS

Advertisements not exceeding 30 words cost $3.00. Additional words 10 cents each.

NON-COMMERCIAL CLASSIFIED ADVERTISING RATES WILL BE INCREASED BEGINNING WITH THE JUNE, 1961 ISSUE TO $4.00 FOR 30 WORDS. ADDITIONAL WORDS 15 CENTS EACH.

Commercial classified advertisements—minimum 30 words $20.00; 60 cents per additional word.

All classified ads payable in advance. Remittance must accompany order for insertion.

Please do not ask for the names of classified advertisers in the JOURNAL who use box numbers. We accept such advertisements with the understanding that this information will not be released. Address replies or inquiries to the box number shown in the advertisement. They are promptly forwarded to the advertiser.

YOUR present income can be doubled or tripled by the application of scientific business principles. Skeptics and others may pay for this information out of their increased income. Write Dr. Edwin Probber, 228 Jericho Turnpike, Floral Park, N. Y.

SACRIFICING well-established practice of 17 years, Chicago, in modern, air-conditioned medical center in choicest location. Completely equipped, four-room suite with switchboard and janitorial services. Leaving state. Write 302, c/o A.P.A., 3301 16th St., N. W., Washington 10, D. C.

PATIENT EDUCATION IS INDICATED EVERY DAY IN EVERY OFFICE.

FOOT FACTS

Publications

P. O. BOX 985

MIAMI BEACH 39, FLORIDA

ESTABLISHED practice, 3 years old. Located in city upstate N. Y. Solid industrial area. Population over 25,000. Only podiatrist. Grossed $10,000 last year. Selling to continue education. Write 304, c/o A.P.A., 3301 16th St., N. W., Washington 10, D. C.

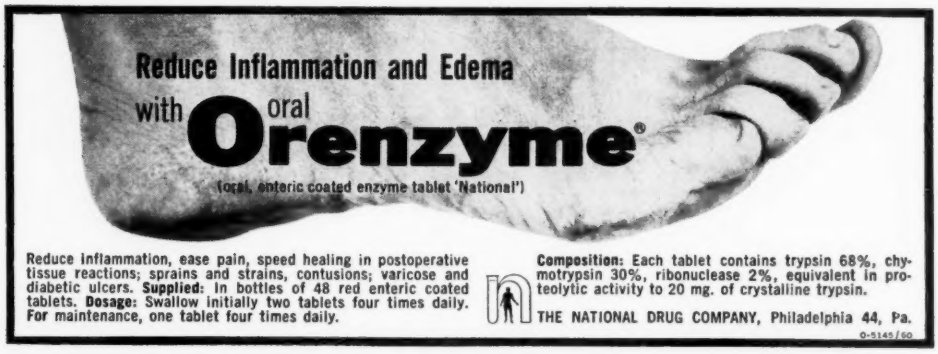
FOR SALE: 6 room office in large medical building in North Ohio. Fully equipped with private parking for doctors and patients. Heat and air-conditioning furnished. Low rent. For more particulars, write 306, c/o A.P.A., 3301 16th St., N. W., Washington 10, D. C.

REASONABLE: Small North Florida practice, modern equipment, ground floor opposite City Hall. Drawing population 150,000, growth limited by ability only. Other interests. Write 308, c/o A.P.A., 3301 16th St., N. W., Washington 10, D. C.

SERVING NATIONALLY

Motorized Chairs — XRM X-Rays — Lights — Treatment Cabinets — Ultra Sounds — Drills Whirlpools — Ship and Install Anywhere — Low Down Payments — Low Cost Financing

SURGICAL SUPPLY SERVICE
825 Walnut St.; Phila. 7, Pa. WAlnut 5-5652

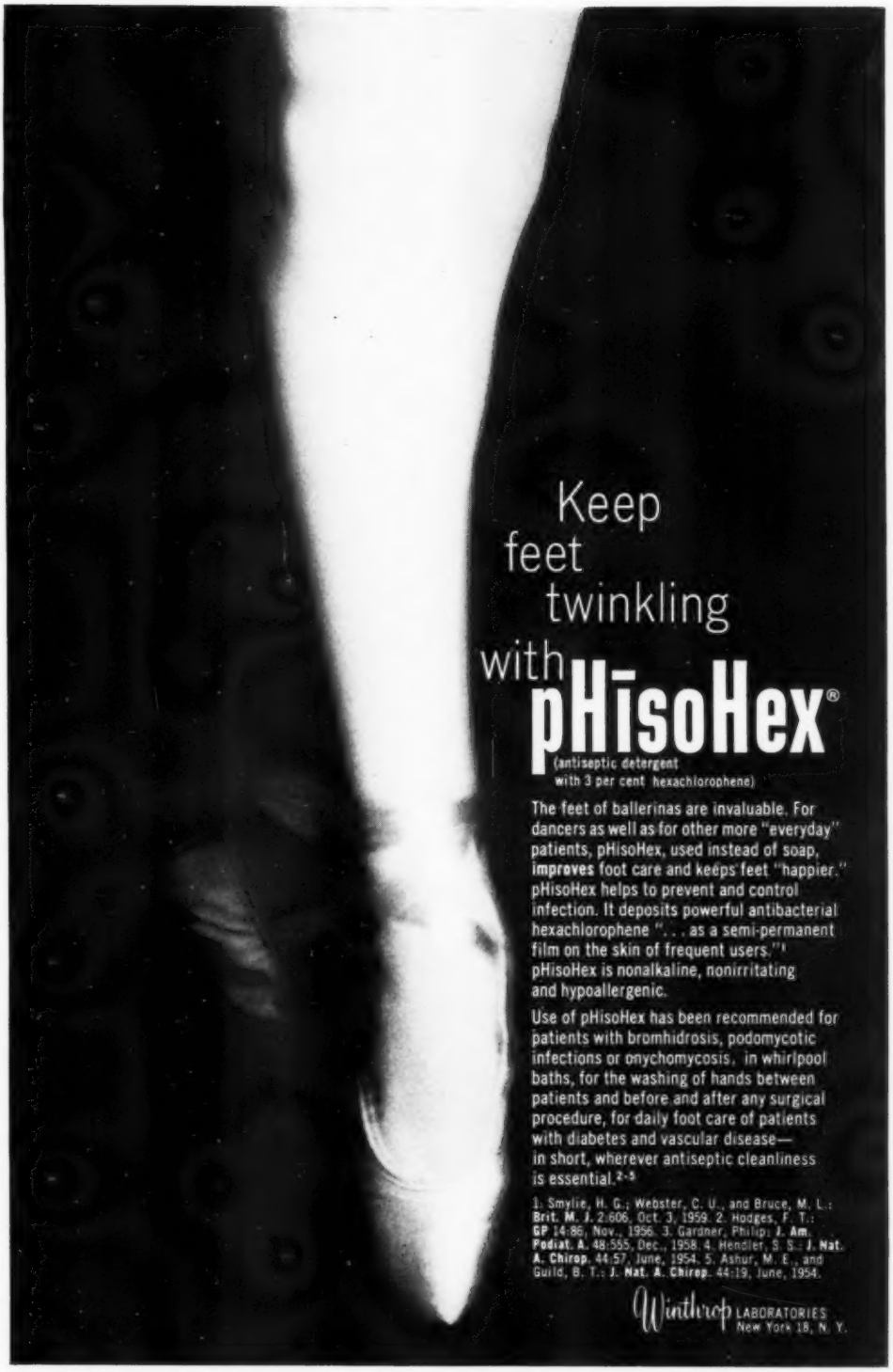


Reduce inflammation, ease pain, speed healing in postoperative tissue reactions; sprains and strains, contusions; varicose and diabetic ulcers. **Supplied:** In bottles of 48 red enteric coated tablets. **Dosage:** Swallow initially two tablets four times daily. For maintenance, one tablet four times daily.

Composition: Each tablet contains trypsin 68%, chymotrypsin 30%, ribonuclease 2%, equivalent in proteolytic activity to 20 mg. of crystalline trypsin.

THE NATIONAL DRUG COMPANY, Philadelphia 44, Pa.

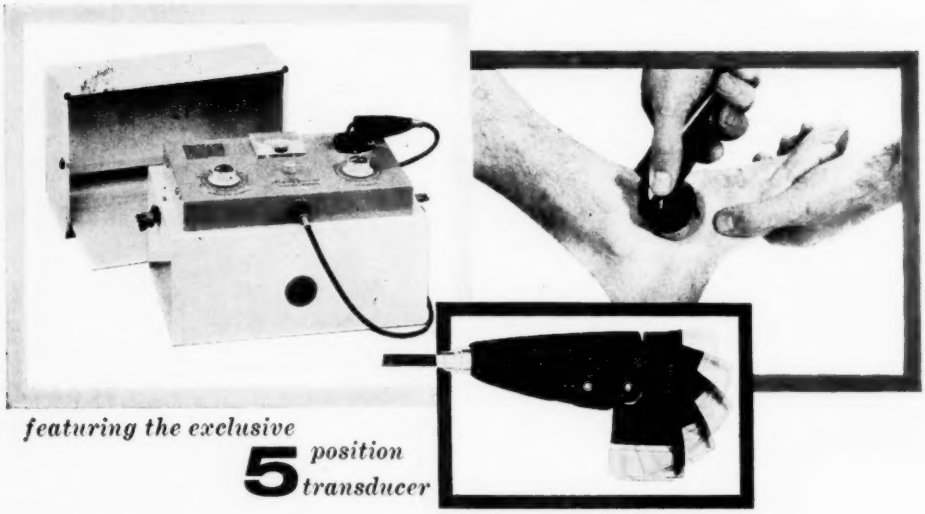
0-5145/60


Keep
feet
twinkling
with
pHisoHex®
(antiseptic detergent
with 3 per cent hexachlorophene)
The feet of ballerinas are invaluable. For dancers as well as for other more "everyday" patients, pHisoHex, used instead of soap, improves foot care and keeps feet "happier." pHisoHex helps to prevent and control infection. It deposits powerful antibacterial hexachlorophene "... as a semi-permanent film on the skin of frequent users."[1] pHisoHex is nonalkaline, nonirritating and hypoallergenic.
Use of pHisoHex has been recommended for patients with bromhidrosis, podomycotic infections or onychomycosis, in whirlpool baths, for the washing of hands between patients and before and after any surgical procedure, for daily foot care of patients with diabetes and vascular disease—in short, wherever antiseptic cleanliness is essential.[2-5]
1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: Brit. M. J. 2:606, Oct. 3, 1959. 2. Hodges, F. T.: GP 14:86, Nov., 1956. 3. Gardner, Philip: J. Am. Podiat. A. 48:555, Dec., 1958. 4. Hendler, S. S.: J. Nat. A. Chirop. 44:57, June, 1954. 5. Ashur, M. E., and Guild, B. T.: J. Nat. A. Chirop. 44:19, June, 1954.
Winthrop LABORATORIES
New York 18, N. Y.

designed with the podiatrist in mind

THE BIRTCHER
MEGASON VI
ULTRASONIC UNIT

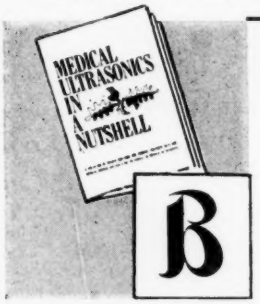
available as a portable or table model



featuring the exclusive **5** *position transducer*

No other ultrasonic unit offers so many features to the podiatrist. The 5 position transducer adjusts at a touch of the trigger to any one of 5 treatment positions. The 5 CM^2 crystal permits direct contact treatment over concave areas. Fully waterproof too, for underwater treatment. So ruggedly built that it carries a full *two-year-guarantee!* A genuine Birtcher ultrasonic at a new all-time low price.

send for new 64-page booklet "MEDICAL ULTRASONICS IN A NUTSHELL"



THE BIRTCHER CORPORATION
Department JP-361
4371 Valley Blvd., Los Angeles 32, California

☐ Send me MEDICAL ULTRASONICS IN A NUTSHELL
☐ I would like a demonstration in my office

Dr._____

Address_____

City_____ Zone_____ State_____